January 4, 2018

Randal Barnes, Administrator
Valley View Nursing & Rehabilitation
1140 North Allumbaugh Street
Boise, ID 83704-8700

Provider #: 135098

Dear Mr. Barnes:

On December 18, 2017, a survey was conducted at Valley View Nursing & Rehabilitation 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. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign the Form.
CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by January 15, 2018. Failure to submit an acceptable PoC by January 15, 2018, may result in the imposition of penalties by February 8, 2018.

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.

Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate).

Remedies recommend to CMS include the following:

- Civil Money Penalty
Denial of payment for new admissions effective **March 18, 2018.** [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 **June 16, 2018**, 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 **March 18, 2018** 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:


Go to the middle of the page to **Information Letters** section and click on **State** and select the following:
This request must be received by January 15, 2018. If your request for informal dispute resolution is received after January 15, 2018, 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,

David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures
June 20, 2018

Randal Barnes, Administrator
Valley View Nursing & Rehabilitation
1140 North Allumbaugh Street
Boise, ID 83704-8700

Provider #: 135098

Dear Mr. Barnes:

Enclosed are the findings of the Informal Dispute Resolution decision.

Also enclosed you will find an amended Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies that incorporates all revisions based on the Informal Dispute Resolution Panel's decision. Please resubmit the facility's Plan of Correction for the deficiencies listed and return the Form CMS-2567 and State Form (if applicable) to this office by July 6, 2018. This amended Statement of Deficiencies and Plan of Correction, Form CMS-2567 will become the facility's survey of record.

If you have any questions, comments or concerns, please contact this office at (208) 334-6626, option 5. Thank you for your participation in this process.

Sincerely,

DEBRA RANSOM, R.N., R.H.I.T, Chief
Bureau of Facility Standards

Enclosures
The following deficiencies were cited during the federal recertification survey conducted at the facility from December 11, 2017 through December 18, 2017.

The surveyors conducting the survey were:
Brad Perry, LSW, Team Coordinator
Linda Kelly, RN
Teresa Kobza, RD
Edith Cecil, RN

Survey Abbreviations:
AD = Activity Director
ADL = Activities of Daily Living
ADON = Assistant Director of Nursing
BIMS = Brief Interview for Mental Status
CDC = Center for Disease Control
CDM = Certified Dietary Manager
CM = centimeter
CNA = Certified Nurse Assistant
C&S = culture and sensitivity
DON = Director of Nursing
e. coli = Escherichia Coli
ESBL = Extended Spectrum Beta Lactamase
I&A = Incident and Accident
IBS = Irritable Bowel Syndrome
KS = Kitchen Staff
LPN = Licensed Practical Nurse
LSW = Licensed Social Worker
MAR = Medication Administration Record
MDS = Minimum Data Set assessment
MG = milligram(s)
ML = milliliter(s)
OT = Occupational Therapy/Therapist
PT = Physical Therapy/Therapist
PRN = As Needed
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§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.
§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review and interview, it was determined the facility failed to ensure the dignity of residents was maintained. This was true for 2 of 18 sampled residents (#'s 57 and 59). Resident # 59 experienced psychosocial harm when she had ongoing embarrassment and a decline in her feelings of self-worth after she was not provided the care and assistance necessary for bladder and bowel incontinence, and she did not consistently receive showers to prevent body odors. Resident #57 experienced the potential for harm when staff responded in a disrespectful way to his requests.

Findings include:

1. Resident #59 was admitted to the facility on 10/25/17 with diagnoses that included chronic kidney disease, history of urinary tract infections (UTIs), chronic cystitis, and irritable bowel syndrome (IBS).

An initial Minimum Data Set (MDS) assessment, dated 11/1/17, documented Resident #59 was cognitively intact, was frequently incontinent, and

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This requirement was not met as evidenced by the determination that the facility failed to ensure the dignity of residents was maintained when a resident #59 experienced psychosocial harm when she had embarrassment and a decline in her feelings of self-worth after she was not provided the care and assistance necessary for bladder and bowel continence and did not consistently receive showers. #57 experienced the potential for harm when staff responded in a disrespectful way to his requests.

1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

Resident #59 has discharged from the facility, unable to complete any corrective
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required extensive assistance of one staff member for toileting. The MDS documented Resident #59 required physical assistance of one staff member with bathing.

a. Resident #59’s Bowel and Bladder Elimination Care Plan, initiated 10/25/17, documented she required extensive assistance from two staff members with toilet transfers, incontinence product change, and peri-care. The care plan documented staff were to provide peri-care after each incontinent episode. The care plan documented she had a toileting schedule, and to provide as needed assistance as well.

A Grievance Report, dated 10/31/17, documented Resident #59 activated her call light when she needed to go to the restroom and staff did not respond for 20-30 minutes. The report documented Resident #59 sometimes could not hold her bladder anymore and she experienced incontinence episodes. The report documented Resident #59 had a urinary rash and should not be left in soiled incontinence products.

On 12/12/17 at 9:30 am, Resident #59 activated her call light and Certified Nursing Assistant (CNA) #5 entered the room. Resident #59 stated she had to go to the bathroom. CNA #5 stated she would assist Resident #59 shortly, turned the call light off, and left the room.

On 12/12/17 at 9:43 am, Resident #59’s room door was open and she was sitting in her room with no clothing or undergarments on her bottom half; she was exposed to the hallway. Resident #59 stated she had taken her clothes off because she had “an accident with diarrhea” and did not

action.

Resident #57 was assessed by the LSW or designee on 1/8/2018 regarding dignity concerns related to the conversation and no concerns were identified by the resident.

2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

Residents were audited for dignity concerns through interview &/or observation by facility managers on or before 2/6/18. Identified concerns were corrected at the time identified. And appropriate staff education was provided as indicated.

3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.

Staff were reeducated before 2/6/18 by DON or designee on the purpose and intent of the regulation and resident’s rights for dignity. Education related to caring for residents with Dementia was completed for direct care staff.

4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is
want to sit in her own feces. CNA #4, CNA #5, and CNA #6 walked by resident #59's room without noticing the state of Resident #59's undress, until notified by a surveyor that Resident #59 needed assistance. CNA #5 and CNA #6 then entered the room to assist Resident #59 with peri-care.

On 12/12/17 at 9:55 am, Resident #59 stated she had activated her call light earlier and a staff member had entered her room, turned off the call light, and told her she would be right back. Resident #59 stated she waited for several minutes, but could not hold her bowels anymore and had "an accident." Resident #59 stated she had cystitis and IBS and when "she needed to go she needed to go now." Resident #59 stated it was "embarrassing" having to sit in one's own excrement and it made her "feel worthless." Resident #59 stated she took her incontinence product off and tried to clean herself up as best she could. Resident #59 stated she did not want to sit in feces and did not want skin breakdown. Resident #59 stated she had a sore on her side under her incontinence products and it was from incontinence issues.

On 12/13/17 at 2:28 pm, Resident #59 stated she developed a bladder infection just recently. Resident #59 contributed the bladder infection to staff not responding to her call light and staff rushing through peri-care. Resident #59 stated she experienced four incontinence episodes the previous night and the first two times, staff took 20-30 minutes to respond. Resident #59 stated the third time it happened she took herself to the bathroom and did not use her call light. Resident #59 stated she was told to not take herself to the sustained will not recur.

Beginning the week of 1/15/2018, the IDT will complete rounds to audit dignity concerns. Nursing leadership/designee will audit the shower schedule 5 times weekly for 2 weeks, then 2 times weekly for 4 weeks. Rounds will be completed 5 times weekly for 2 weeks, then 2 times weekly for 4 weeks. Identified concerns from audits will be corrected at the time identified, as possible, and appropriate staff education will be provided as indicated. Results of the rounds will be presented in the facility QAPI meeting monthly for three months. Any identified negative trends will be addressed through system modification and staff education as appropriate.

5.) Date Corrective action will be completed: February 6, 2018
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bathroom and to wait for assistance. Resident #59 stated it was frustrating waiting for staff and having an incontinence episode while waiting. Resident #59 stated it was embarrassing to go in her incontinence product and then sit in her own urine. Resident #59 stated she also did not want to sit in urine because it could lead to skin breakdown. Resident #59 stated sometimes staff would come into her room, turn off her call light and tell her they would be back, and then wouldn't come back. Resident #59 stated she "hoped" staff would come sooner to prevent skin breakdown or more incontinence issues.

b. Resident #59's Activities of Daily Living (ADL) Care Plan, revised 10/25/17, documented she required minimal assistance of 1 staff member with bathing and showers.

Resident #59's 10/25/17 through 12/14/17 ADL Shower Documentation Survey Report documented she was scheduled to receive showers on Wednesdays and Sundays. The flowsheet documented Resident #59 did not receive a shower on 11/3/17, 11/10/17, 11/17/17, 11/20/17, 11/24/17, 11/27/17, 12/1/17, and 12/10/17. According to the flowsheet, the longest length of time Resident #59 went without a shower was 11 days, between 11/15/17 and 11/26/17.

Grievance Reports, dated 11/10/17 and 11/13/17, documented Resident #59 was not receiving two showers a week. The report documented Resident #59 was being treated for "urinary sores." The findings area of the Grievance Report documented Resident #59 was not receiving her showers due to staffing issues. The
**SUMMARY STATEMENT OF DEFICIENCIES**

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**Event ID:** 4T4N11  **Facility ID:** MDS001810

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Report documented when the facility was short staffed they reassigned the shower aides to cover the shortages in general resident care.

On 12/13/17 at 2:28 pm, Resident #59 stated she was frustrated that the facility was not providing her with at least two showers a week. Resident #59 stated she was used to showering more than twice weekly and she did not receive one shower a week on some occasions. Resident #59 stated this was an ongoing concern as she did not like "feeling dirty" and, "I hate it when I smell."

On 12/15/17 at 11:39 am, the Assistant Director of Nursing (ADON) stated when staff members respond to call lights and they are instructed to not turn the call off until the residents' needs were met. The ADON stated the facility had a call light response time issue that was directly related to staffing issues. The ADON stated if people called in sick, the facility would reassign the restorative nursing aides first to general resident care, and then the bath aides. The ADON stated she was aware of residents not receiving shower and the lack of showers was related to the lack of staffing as well.

On 12/18/17 at 8:17 am, Resident #59's Interested Party stated he/she frequently visited the resident. The Interested Party stated he/she had witnessed Resident #59 activate her call light and staff did not respond in time to take her to the bathroom. The Interested Party stated he/she had timed the CNAs response times and they varied from 5 minutes to 30 minutes. The Interested Party stated Resident #59 had called him/her multiple times upset about occurrences of incontinence due to staff not responding to the
resident's call light, and lack of showers. The Interested Party stated the facility had not provided Resident #59 with two showers a week as promised. The Interested Party stated he/she had filed grievances related to these issues and the facility had not resolved the issues. The Interested Party stated the facility told him/her that they were short staff and were working on adding more staff. The Interested Party stated the residents should not have to suffer because the facility was short staffed.

2. On 12/12/17 at 10:00 am, Resident #57 was observed leaning on a walker in the hallway just outside his room. Registered Nurse (RN) #3 told the resident to "be patient," and stated, "You will get your orange juice. The CNA knows and went to get it." Resident #57 responded in a quiet, inaudible voice and RN #3 stated, "She has to go to the kitchen to get your orange juice. You have to be patient. If I asked you to make me a cake, would you be able to get it right away? No, so you have to be patient."

RN #3 left Resident #57 standing in the hallway leaning on his walker. The resident stood in place a short while longer and returned to his room.

On 12/14/17 at 3:00 pm, Resident #57 stated, "No," when asked if RN #3 treated him with dignity. He then repeatedly asked, "Can I get up and sit in the chair?"

On 12/15/17 at 3:45 pm, the RN Staff Development Director stated RN #3 had not yet received training for interacting with residents with dementia.
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<td>On 12/18/17 at 2:00 pm, the facility provided the orientation training packet for RN #3 that included a Resident Rights Policy signed by RN #3 and dated 7/25/17. The policy informed staff that the &quot;residents are our highest priority. Each of our [staff] will treat all residents with kindness, respect, and dignity.&quot;</td>
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<td>F 559</td>
<td>Choose/Be Notified of Room/Roommate Change</td>
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<td>CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on resident interview and record review, it was determined the facility failed to provide residents the opportunity to make informed choices regarding room moves. This was true for 1 of 1 (#31) sampled residents The deficient practice created the potential for harm if Resident #31 experienced a diminished sense of self-worth due to lack of control over her environment. Findings include: Resident #31 was admitted to the facility on 8/23/17 with multiple diagnoses which included</td>
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This REQUIREMENT is not met as evidenced by: Based on resident interview and record review, it was determined the facility failed to provide residents the opportunity to make informed choices regarding room moves.

1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.
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septicemia, neurogenic bladder, diabetes Mellitus, atrial fibrillation, hypertension, paraplegia, depression, and a pressure ulcer.

Resident #31's quarterly MDS, dated 11/30/17, documented she was alert and cognitively intact. The MDS documented she required extensive assist from, or was totally dependent on, staff for cares.

A Grievance Report completed by Resident #31, dated 10/23/17, documented that since she moved to the second floor, her care had "gone downhill" and she would like to be moved back downstairs in a room she could share with someone. The grievance documented that the move upstairs had "really depressed" her, and that she felt "a strong need to get back downstairs and have the people who know how to care for me do it." The grievance report also included multiple care areas Resident #31 was concerned about.

The facility responded to the grievance for the care issues, but did not address the psychosocial response Resident #31 had to the move.

On 12/11/17 at 2:22 pm, Resident #31 stated she was moved from the first floor to her current room on the facility's second floor approximately 2 months ago. She stated her insurance changed and could no longer have a private room. She stated she was told she would have to have a roommate or she could move upstairs. Resident #31 stated she chose to move to the second floor because she was under the impression she would not have a roommate, but was moved into a room with a roommate. Resident #31 stated the

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Resident #31- Resident will be interviewed and presented with choice options in determining her room placement. IF resident desires her room will be changed when readily available.

2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

Residents/family who show an interest in a room change will be given the opportunity to tour available room(s) to enable an informed decision.

3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.

Education will be provided to IDT related to process for and identifying residents that may wish room change.

Social Services or designee will complete room change form. The room change form will be signed by Resident &/or family and facility designee. A copy of the Notification of Room Change form will be given to resident/family.

Residents who have a change in room will be placed on alert charting for 72 hours to monitor change in mood or behavior r/t room change.

Grievances will be reviewed weekly by
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Staff told her there was not any difference between the first and second floors. She stated she "immediately recognized the difference." She stated the first floor was elaborately decorated for Christmas, whereas there was sparse decoration on the second floor. Resident #31 stated since moving to the second floor it took longer for staff to respond to call lights, the room temperature was too warm, and staff often had the privacy curtain between beds which blocked the air from the heating/cooling unit under the window. Resident #31 stated she had asked for a bed by the window but had not been moved, and had received no explanation as to why. She stated she had a small fan which helped, but staff had knocked it on the floor and the fan broke. The facility did not replace her fan, but instead brought a facility fan in for her. Resident #31 stated, "I can see how my body and mind are not as happy or as positive as I was when I was downstairs."

Resident #31 was moved to a different floor without the benefit of informed choice and was not assisted to move to the area of the facility where she would be most comfortable.

| F 580 | Notify of Changes (Injury/Decline/Room, etc.) | | F 580 | | | 2/6/18 |

§483.10(g)(14) Notification of Changes.

1. A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-
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<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<td>F 580</td>
<td>Continued From page 11</td>
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(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).

(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various
F 580 Continued From page 12

locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interviews, it was determined the facility failed to ensure a resident's responsible party was notified of a resident's fall. This was true for 1 of 20 (#68) sampled residents. This deficient practice created the potential for harm when Resident #68's responsible parties were not notified of falls. Findings include:

Resident #68 was admitted to the facility on 11/12/13 with diagnoses that included osteoporosis and osteoarthritis.

A quarterly Minimum Data Set (MDS) assessment, dated 11/12/17, documented Resident #68 was cognitively intact.

Resident #68's Incident and Accident (I&A) Report and Nurses Notes, dated 4/29/17, documented she experienced an unwitnessed fall out of bed. The report documented a call was made to Resident #68's Interested Party #1 and there was no response.

A Social Service Review Note, dated 5/22/17, documented Resident #68 requested both Interested Party #2 and Interested Party #1 be contacted with all health decisions.

Resident #68's I&A Report, dated 8/25/17, documented she experienced an unwitnessed fall out of her wheelchair, while in her room. The
**SUMMARY STATEMENT OF DEFICIENCIES**

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A Nurse's Note, dated 8/25/17, documented a call was made to Resident #68's Interested Party #1 but the phone was disconnected. There was no documentation the facility contacted or attempted to contact Interested Party #2.

On 12/12/17 at 8:23 am, Resident #68 stated she wanted Interested Party #2 to receive information when things were wrong.

On 12/15/17 at 3:10 pm, the Assistant Director of Nursing (ADON) stated if an interested party's phone was disconnected and or they did not answer, the facility should attempt to contact someone else.

**PROVIDER'S PLAN OF CORRECTION**

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<td>F 580</td>
<td>designee. The audit included the notification of resident's responsible party and MD. Identified concerns were corrected at the time of the audit and appropriate staff education was provided as indicated.</td>
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</table>

3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.

Licensed Nursing staff were reeducated by DON or designee and provided instruction on the process for notification of resident, Responsible person and MD for incidents or medical changes that result in significant change.

During the 5 time per week clinical team meeting, the notes and/or incident reports will be monitored to identify potential significant changes and responsible parties and MD were appropriately notified.

4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur.

The IDT will complete an audit of incident/accident reports to ensure compliance the regulation related to change in condition. Audits will be completed 5 times weekly for 4 weeks, then 2 times weekly for 4 weeks.
### Statement of Deficiencies and Plan of Correction

**Valley View Nursing & Rehabilitation**

**Streets Address, City, State, Zip Code:**

1140 North Allumbaugh Street

Boise, ID 83704

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (each deficiency must be preceded by full regulatory or LSC identifying information)</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>Completion Date</th>
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<td>F 580 Continued From page 14</td>
<td>F 580 Identified concerns will be corrected at the time identified, if possible, and with appropriate staff education provided as indicated. Results of the incident/accident audits will be presented in the facility QAPI meeting monthly for three months, with any identified trends addressed through system modification and staff education as appropriate. 5.) Date Corrective action will be completed: February 6, 2018</td>
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<td>2/6/18</td>
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**F 583 Personal Privacy/Confidentiality of Records**

**CFR(s):**

483.10(h)(1)-(3)(i)(ii)

- **§483.10(h) Privacy and Confidentiality.** The resident has a right to personal privacy and confidentiality of his or her personal and medical records.
- **§483.10(h)(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.**
- **§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.**
F 583  Continued From page 15

§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.

(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.

(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, it was determined the facility failed to ensure a resident's privacy during peri-care. This was true for 1 of 20 sample residents (#37). This deficient practice created the potential for harm should Resident #37 become embarrassed if others observed her receiving peri care and her exposed body was seen by others. Findings include:

Resident #37 was admitted to the facility on 9/30/17 with diagnoses including dementia with behavioral disturbances.

Resident #37’s admission Minimum Data Set (MDS) assessment, dated 10/7/17, documented she was severely cognitively impaired and required extensive assistance of two staff members for toileting.

On 12/13/17 at 11:37 am, Certified Nursing Assistant (CNA) #4 assisted Resident #37 into the bathroom. CNA #4 left the door to the bathroom open. Resident #37’s roommate was in

F 583  Continued From page 15

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<tr>
<th>Event ID: 4T4N11</th>
<th>Facility ID: MDS001810</th>
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### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 135098

**Date Survey Completed:** 12/18/2017

**Valley View Nursing & Rehabilitation**

**Street Address, City, State, Zip Code:**

1140 North Allumbaugh Street, Boise, ID 83704

### Summary Statement of Deficiencies

Each deficiency must be preceded by full regulatory or LSC identifying information.

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<th>ID</th>
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<td>F 583</td>
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#### F 583

Continued From page 16

The room. The blinds of the room were open and the curtains were drawn back, leaving an unobstructed view of Resident #37 while she was taken into the bathroom. CNA #4 removed Resident #37’s clothes from her lower body. People could be seen walking in the area outside the window to the resident's room. Resident #37's roommate reached for the privacy curtain closest to her and drew it closed. Resident #37's roommate stated she was closing the curtain to give Resident #37 some privacy.

On 12/14/17 at 9:03 am, CNA #4 stated normally she closes the curtains or ensures there was privacy, however, she was flustered because Resident #37 was upset when taken into the bathroom.

On 12/15/17 at 11:38 am, the Assistant Director of Nursing stated staff should close doors or curtains when they were assisting resident in the bathroom.

**Resident rounds and random interviews were conducted for identifying any privacy concerns by facility managers. Identified concerns were corrected at the time identified with appropriate staff education provided as indicated.**

3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.

**Staff were reeducated by DON or designee on the purpose and intent of the facility expectations for resident privacy. Education also included instruction on how to identify issues/concerns related to this requirement.**

4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur.

**IDT will complete rounds to identify any privacy concerns, 5 times weekly for 4 weeks, then 2 times weekly for 4 weeks. Identified concerns will be corrected at the time identified, as possible, with appropriate staff education provided as indicated.**

**Results of the rounds will be presented in the facility QAIP meeting monthly for three months, with any identified negative trends addressed through system modification and staff education as necessary.**
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<tr>
<td>F 610</td>
<td>SS=D</td>
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<td>Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)</td>
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<td>2/6/18</td>
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§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview, it was determined the facility failed to ensure a resident's fall was thoroughly investigated. This was true for 1 of 4 (#37) residents reviewed for falls and created the potential for harm due to a lack of an investigation to rule out abuse or neglect. Findings include:

Resident #37 was admitted to the facility on 9/30/17 with diagnoses including dementia and

5.) Date Corrective action will be completed: February 6, 2018

1.) What corrective action(s) will be

This requirement was not met as evidenced by the determination that the facility failed to ensure a resident’s fall was thoroughly investigated.
F 610 Continued From page 18
fracture of the right femur.

Resident #37’s admission Minimum Data Set (MDS) assessment, dated 10/7/17, documented she was severely cognitively impaired and required extensive assistance of two staff members for bed mobility, transfers, and toileting. The MDS documented Resident #37 had a history of falls.

Resident #37’s Fall Risk Assessment, dated 9/30/17 documented she was at high risk of falling.

Resident #37’s clinical record documented she experienced eight unwitnessed falls between 10/4/17 and 12/11/17.

Resident #37’s Nurse’s Note, dated 10/29/17 at 6:44 am, documented Resident #37 was, “found sitting on the floor saying, ‘Help me, help me.’... [Resident #37] was assisted into chair.” The facility did not document an investigation for this fall.

On 12/15/17 at 10:54 am, the Assistant Director of Nursing (ADON) stated she was unaware of the lack of investigation into Resident #37’s fall on 10/29/17.

On 12/15/17 at 3:10 pm, the ADON stated the facility missed investigating the fall on 10/29/17 at 6:22 am.

accomplished for those residents found to have been affected by the deficient practice.

Incident/Accident report for Resident #37’s fall on 10/29/17 has been reviewed and care plan updated as needed. The RN, who failed to complete the incident report, has received education r/t completing incident reports.

2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

Progress notes from 10/29/17 to present were audited to ensure that there are no additional incidents/accidents identified without a corresponding incident/accident report by DON or designee. Identified concerns were corrected at the time identified with appropriate staff education provided as indicated

3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.

Staff were reeducated by DON or designee and provided instruction on expectations of completion of incident/accident reports and how to identify issues/concerns related to this requirement.
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:**

Valley View Nursing & Rehabilitation

**Street Address, City, State, Zip Code:**

1140 North Allumbaugh Street, Boise, ID 83704

**Date Survey Completed:**

12/18/2017

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<tr>
<td>F 610</td>
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<td>F 610</td>
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<td>Progress notes will be reviewed by DON/Designee 5 times weekly X 4 weeks, during the clinical meeting, to identify potential allegations of abuse or incidents requiring review and investigation.</td>
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<td>4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur.</td>
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<td>DON/Designee will complete an audit to review progress notes. Audits will be completed 5 times weekly for 4 weeks, then 2 times weekly for 4 weeks. Identified concerns will be corrected at the time identified, as possible, and appropriate staff education will be provided as indicated.</td>
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<td>Results of the audits will be presented in the facility QAPI meeting monthly for three months, with any identified negative trends addressed through system modification and staff education as appropriate.</td>
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<td>5.) Date Corrective action will be completed: February 6, 2018</td>
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<tr>
<td>F 656</td>
<td>SS=D</td>
<td>Develop/Implement Comprehensive Care Plan</td>
<td>F 656</td>
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<td>§483.21(b) Comprehensive Care Plans</td>
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<td>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the</td>
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**F 656**

SS=D

**Develop/Implement Comprehensive Care Plan**

CFR(s): 483.21(b)(1)

"§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the"
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:**

- A. Building: _______________________
- B. Wing: _______________________

**Multiple Construction**

**Date Survey Completed:** 12/18/2017

**Name of Provider or Supplier:**

**Valley View Nursing & Rehabilitation**

**Street Address, City, State, Zip Code:**

1140 North Allumbaugh Street

Boise, ID 83704

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| F 656 Continued From page 20 | resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

   (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

   (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

   (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

   (iv) In consultation with the resident and the resident's representative(s)-

   (A) The resident's goals for admission and desired outcomes.

   (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

   (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, it was determined the facility failed to implement comprehensive resident-centered care plans. This was true for 1 of 4 (#7) residents reviewed for bowel and bladder elimination care plans and had the potential for harm if residents were provided with inadequate bowel and bladder care. Findings include:

Resident #7 was readmitted to the facility on 9/3/17 with multiple diagnoses, including Parkinson's disease and dementia.

The 9/10/17 admission Minimum Data Set assessment documented Resident #7 experienced moderate cognitive impairment, was frequently incontinent of bladder, incontinent of bowel, and was totally dependent on 2 staff for toileting.

A bowel and bladder elimination care plan, dated 8/29/17, documented Resident #7 required 2 staff assistance for toilet transfers, brief changes and peri-care when incontinent. The care plan did not document when staff were to assist the resident to the toilet, if the resident was on a toileting schedule or when to check the resident's incontinent brief.

A bowel and bladder evaluation, dated 12/5/17, documented Resident #7 was a candidate for scheduled toileting (timed voiding).

A December 2017 bladder report documented Resident #7's incontinent brief was "soaked" 5 times from 12/5/17 to 12/11/17.

A nursing note, dated 12/9/17 at 2:05 pm,

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<td>F 656 Development Comprehensive Care Plan</td>
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<td>This requirement was not met as evidenced by the determination that the facility failed to implement comprehensive resident-centered care plans for bowel and bladder elimination.</td>
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<td>1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</td>
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<td>Resident #7 has been reevaluated using the Bowel and Bladder evaluation and her plan of care has been updated to accurately reflect the required assistance.</td>
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<td>2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;</td>
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<td>The DON or designee reevaluated current residents with the Bowel and Bladder evaluation. Once reevaluated the residents plan of care was reviewed and updated as necessary to reflect the residents individualized bowel and bladder care need.</td>
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<td>Upon admission, quarterly or with significant change in condition the resident will be re-evaluated for their bowel and bladder continence.</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td>F 656</td>
<td>Continued From page 22 documented Resident #7 was found on the hallway floor with &quot;soaked through clothing.&quot; On 12/13/17 at 3:09 pm, CNA #12 said Resident #7 was incontinent of bowel and bladder. On 12/13/17 at 4:06 pm, Resident #7's Interested Party said the resident was incontinent of bowel and bladder and the resident's brief was to be checked and changed as needed. On 12/15/17 at 9:49 am, CNA #13 said she was not sure what Resident #7’s elimination care plan had been prior to the fall on 12/9/17 and stated she &quot;thought&quot; she changed the resident's brief prior to lunch that day. CNA #13 said she normally tried to change Resident #7's brief before and after meals with assistance from another staff member. On 12/15/17 at 10:03 am, LPN #3 said she thought the resident was to be changed every 2 hours as well as before- and after meals. On 12/14/17 at 4:08 pm and on 12/15/17 at 11:34 am, the Director of Nursing said Resident #7's elimination care plan did not document when the staff were to assist the resident to the toilet or when to check and change the resident's brief.</td>
<td></td>
<td>F 656</td>
<td>3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. Licensed nursing staff were reeducated by DON or designee on the purpose and intent of assessing for bowel and bladder continence and provided instruction on how to identify issues/concerns related to this requirement. 4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur. DON or designee will audit 5 residents care plans for Bowel and Bladder weekly for 4 weeks, then audit 2 resident care plans per week for 4 weeks to identify discrepancies between the care need assessed. The Care plan will be updated as necessary. Results of the audits will be presented in the facility QAPI meeting monthly for three months’ with any identified negative trends addressed through education and modification of the performance plan as appropriate. 5.) Date Corrective action will be completed: February 6, 2018</td>
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F 657 Continued From page 23

§483.21(b) Comprehensive Care Plans
§483.21(b)(2) A comprehensive care plan must be-
(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined the facility failed to ensure residents' care plans were regularly reviewed and revised as warranted. This was true for 3 of 20 residents (#31, #37, and #51) reviewed for care plan revisions and created the potential for harm if care was not provided or decisions were made based on inaccurate or

F 657 Care Plan Timing and Revision

This requirement was not met as evidenced by the determination that the facility failed to ensure residents care plans were regularly reviewed and revised as warranted.
了起来信息。发现包括：

1. 37号居民于9月30日入住该设施，诊断为包含痴呆症的伴有行为障碍。

该入院最低数据集（MDS）评估，日期10/7/17，文档37号居民严重认知不良。

37号居民的认知障碍护理计划，修订10/11/17，文档工作人员要求以是/否问题来确定其需要，减少干扰，以简单直接的句子与该居民交流，提供提示，如果该居民变得激怒时，停止沟通努力。

该护理计划没有描述37号居民的行为，或方向当这些行为严重影响到工作人员的护理。

在12/14/17年5:46 pm，经过社会工作者（LSW）#1表示37号居民可能会至，然后改变她的想法。LSW #1表示工作人员应该尝试不同的方法和/或提示，而不是是/否问题。LSW #1表示该当前护理计划应该指导工作人员如何响应37号居民拒绝护理，变得好斗，或告诉工作人员“停止。”LSW #1表示该护理计划应该描述37号居民的行为，并提供工作人员一个“逐步方法”来响应这些行为。

1.) 该矫正行动将对被该错误的实践所影响的该居民将怎么做？

37号居民的认知障碍护理计划被修订并更新，反映了该居民的认知缺陷。

• 行为护理计划被启动，该计划明确哪些行为与认知有关，并为工作人员提供合适的干预措施。

51号居民潜在皮肤缺陷护理计划被该设施的皮肤伤口护士检查，并该护理计划被更新，反映了该居民的护理计划。使用她的个人躺椅。

31号居民活动护理计划被修订并更新，反映了该居民兴趣的偏好和需要在1/10/18。

2.) 如何识别其他可能受到同一错误行为影响的居民和采取什么矫正行动？

居民的护理计划有关于认知障碍被IDT审定，适当更新以反映认知、行为与认知相关，并为工作人员使用合适的干预措施。

DON或指定人审计了该居民的行为。
F 657  Continued From page 25
On 12/15/17 at 10:54 am, the Assistant Director of Nursing (ADON) stated the care plan should reflect the social services assessment and provide staff with direction for assisting Resident #37 when signs/symptoms of dementia and behaviors were present.

2. Resident #51 was readmitted to the facility on 7/12/17 with diagnoses that included urinary retention, urinary tract infection, diabetic cystopathy, and sepsis.

A significant change MDS assessment, dated 10/27/17, documented Resident #51 was cognitively intact, required extensive assistance of 2 staff for transfers and bed mobility, was at high risk for pressure ulcers, and had pressure reducing devices for her bed and chair. The MDS did not document she was on a repositioning program.

The Potential Skin Impairment Care Plan, revised 11/2/17, documented staff were to assist Resident #51 with repositioning and offloading as needed 2-3 times each shift, and encourage the resident to limit her time in a recliner to 1.5 - 2 hours at a time.

A Physician's Order, dated 10/27/17, documented staff were to limit Resident #51’s time in a recliner to 1.5 - 2 hours at a time.

On 12/11/17, Resident #51 was observed sitting uninterrupted in a recliner from 2:28 pm to 4:55 pm.

On 12/13/17 at 10:58 am, Resident #51 stated she preferred sitting in a recliner the majority of care plan related to skin care and revised the plan as appropriate to reflect current residents skin care, use of devices. Identified concerns were corrected at the time identified and appropriate staff education was provided as indicated.

Residents that are bedbound/unable to attend group activities plans of care will be reviewed and updated to reflect resident interest preferences and needs.

3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.

Social Services staff will audit current resident’s care plans to update behaviors and interventions as needed with a cognitive/behavior meeting bi-weekly. Social Services will meet with IDT during monthly Psychotropic meeting to determine best approach to assist resident whose needs may have changed.

Licensed Nursing staff were reeducated by DON or designee regarding the purpose for proper assessment and evaluation of resident care needs in relationship to activities, skin care and interventions to best support the residents plan of care.

Activities will complete a weekly review of resident participation in activities of choice and/or in accordance with
F 657 Continued From page 26

On 12/15/17 at 10:19 am, Certified Nursing Assistant (CNA) #7 stated Resident #51 preferred to read books in a recliner most of the day. CNA #7 stated she was not aware of any positioning restrictions placed on Resident #51’s time in the recliner.

On 12/15/17 at 12:28 pm, the ADON stated she was not aware of Resident #51’s seating preference, but that she expected staff to know residents’ preferences. The ADON stated the care plan was a tool to help staff care for residents.

The facility failed to ensure a resident’s positioning preference was care planned and the care plan updated to reflect her preference.

3. Resident #31 was admitted to the facility on 8/23/17 with multiple diagnoses, including neurogenic bladder, diabetes mellitus, paraplegia, depression, and the presence of a healing pressure ulcer.

The admission MDS assessment, dated 8/30/17, documented Resident #31 was alert, cognitively intact, no range of motion impairments to the upper extremities, and required set-up assistance only for eating.

The Activity Care Plan, dated 9/11/17, documented Resident #31 did not regularly participate in activities due to physical limitations, and included the following interventions:

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<td>assessment, that will occur weekly for 1 month. Nursing will complete a weekly audit of 10 residents, to monitor for implementation of specific interventions in accordance with the resident’s pressure ulcer risk or current skin condition.</td>
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<td>4.)</td>
<td>Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur.</td>
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<td>The IDT will audit 5 resident plans of care weekly for 4 weeks, then audit 2 resident care plans per week for 4 weeks to identify discrepancies between the care plan, resident assessment and implementation of specific interventions. Any discrepancy will be corrected at the time of the finding and the care plan will be updated.</td>
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<td>5.)</td>
<td>Date Corrective action will be completed: February 6, 2018</td>
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<td>Results of the care plan and intervention audits will be presented in the facility QAPI meeting monthly for three months, with any identified negative trends addressed through system modification and staff education as appropriate</td>
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### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 135098  
**Multiple Construction: A. Building:**  
**B. Wing:**  
**Date Survey Completed:** 12/18/2017

**Name of Provider or Supplier:** Valley View Nursing & Rehabilitation  
**Street Address, City, State, Zip Code:** 1140 North Allumbaugh Street, Boise, ID 83704

**Summary Statement of Deficiencies**

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| F 657 | Continued From page 27 | F 657 | * Establish and record prior level of activity participation and interests by talking with the resident, caregivers, and family on admission and as necessary.  
* Provide assistance/escort to activity functions.  
* The resident prefers to watch movies on her portable DVD player.  
* The resident prefers to socialize with family and friends.  
* The resident's preferences included watching movies, word search puzzles, and talking on the phone.  
On 12/13/17 at 1:48 pm, Resident #31 stated she was bedbound and did not attend activities. "There has been no offer of crafts. I am totally left in the dark, makes me feel left out and depressed. They [the facility] don't have enough care [staff] to involve everyone [residents]."  
On 12/14/17 at 10:28 am, the Activity Director stated Resident #31 was provided many in-room activities. When asked if those in-room activities included time spent visiting with staff, the Activity Director stated, "No."  
On 12/15/17 at 9:22 am, Resident #31 stated she would like to participate in the facility's activities program, such as arts and crafts. Resident #31 stated staff included her in a Christmas card activity the day before "for the first time," and that she was "tired" of watching TV, movies, and coloring. The resident said she would like to participate in other facility activities, but staff had not asked whether she was satisfied with her current activities, much of which had been provided by her family. |

**Services Provided Meet Professional Standards:** F 658  
**Completion Date:** 2/6/18
### F 658 Continued From page 28

**SS=D CFR(s): 483.21(b)(3)(i)**

§483.21(b)(3) Comprehensive Care Plans

The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-

(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:

Based on staff interview, and review of clinical records and Incident and Accident Reports (I&A), it was determined the facility failed to ensure the neurological status of residents was consistently assessed after falls with the potential for head injury. This was true for 1 of 4 residents (#37) reviewed for falls and created the potential for harm if changes in a resident's neurological status went undetected and untreated. Findings included:

Resident #37 was admitted to the facility on 9/30/17 with diagnoses that included dementia and fracture of the right femur.

The admission MDS assessment, dated 10/7/17, documented Resident #37 was severely cognitively impaired, required extensive assistance of two staff members for bed mobility, transfers, and toileting, and had multiple falls.

Resident #37's Fall Care Plan, revised 12/11/17, documented staff were to complete neurological assessments after a fall.

Resident #37's Fall Risk Assessment, dated 9/30/17 documented she was at high risk of falling.

---

**F 658 Services provided to meet professional standards**

1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

Unable to complete corrective action for resident #37 past falls.

2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

Residents who had an unwitnessed fall or fall with bump to the head are at risk for this practice. Facility is unable to complete neurological checks for prior falls.

3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.

Licensed Nursing staff were reeducated regarding the completion of neurological assessments.
Review of I&A Reports and clinical records, involving Resident #37, showed the resident had unwitnessed falls on 10/4/17, 10/5/17, 10/11/17, 10/29/17 (times 2), 11/8/17, 11/9/17, and 12/9/17. There was no documentation, in the clinical records, providing evidence of completed neurological assessments following each of these falls.

During an interview, on 12/15/17 at 4:35 pm, UM #2 stated the neurological assessments should be completed following an unwitnessed fall or if a resident hits their head.

In a separate interview, dated 12/15/17 at 4:40 pm, the ADON stated staff were to complete a neurological assessment when residents experience an unwitnessed fall.

Audits were completed to include residents who have an unwitnessed fall or a fall with witnessed hit to their head to ensure neurological checks were completed. Audits will be completed randomly 4 times weekly for 4 weeks, then 2 times weekly for 8 weeks. Identified concerns will be corrected at the time identified, with appropriate staff education provided as indicated.

Results of the neurological check audits will be presented in the facility QAPI meeting for three months (or longer as necessary) beginning in February, with any identified negative trends addressed through system modification and staff education as appropriate.

5.) Date Corrective action will be completed: February 6, 2018
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| F 677 Continued From page 30 | F 677 ADL care provided for Dependent Residents | 1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. | Resident 31, 37, 51, and 68 received assistance with bathing and hygiene by CNA on or before 2/6/18. Residents were interviewed and were satisfied with the assistance provided. | 1. On 12/12/17 at 3:00 pm, 6 of 8 residents attending a resident group interview said they did not always receive scheduled showers when shower aides were reassigned to perform general Certified Nursing Assistant (CNA) duties throughout the facility.  
2. Resident #59 was admitted to the facility on 10/25/17 with diagnoses that included chronic kidney disease, history of urinary tract infection, chronic cystitis, and irritable bowel syndrome.  
The admission Minimum Data Set (MDS) assessment, dated 11/1/17, documented Resident #59 was cognitively intact, frequently incontinent, required extensive assistance of 1 staff for toileting, and the assistance of 1 staff for bathing.  

Residents were reviewed and interviewed by IDT members on or before 2/6/18 for evidence that ADL support including bathing and hygiene needs are met. Any deficient practice was corrected at the time identified and staff education was provided. | 2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken; |
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<th>TAG (X5)</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>F 677</td>
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<td>The Activities of Daily Living (ADL) Care Plan, revised 10/25/17, documented Resident #59 required minimal assistance of 1 staff with bathing and showers. The ADL Report for 10/25/17 through 12/14/17 documented Resident #59 was scheduled to shower on Wednesdays and Sundays, but did not receive a shower on 11/3/17, 11/10/17, 11/17/17, 11/20/17, 11/24/17, 11/27/17, 12/1/17, and 12/10/17. The Report documented Resident #59 was not showered for 11 consecutive days from 11/15/17 to 11/26/17. Grievance Reports, dated 11/10/17 and 11/13/17, documented Resident #59 was not bathed twice weekly because the facility was short-staffed and shower aides were reassigned to general CNA duties. On 12/13/17 at 2:28 pm, Resident #59 stated she was frustrated the facility did not provide her with at least two showers a week. Resident #59 stated she was accustomed to showering more often than twice weekly, but had at times gone an entire week at the facility without a shower. Resident #59 stated she did not like feeling dirty and &quot;hated&quot; it when she smelled. On 12/15/17 at 11:39 am, the Assistant Director of Nursing (ADON) stated unexpected staff absences required the facility to first reassign restorative nursing aides and then bath aides, and said she was aware residents sometimes did not receive showers due to a lack of staffing. On 12/18/17 at 8:17 am, Resident #59's Interested Party stated staff did not always</td>
<td>3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. Nursing staff have been educated by DON or designee regarding the requirements to provide ADL support as indicated in the resident's care plan. 4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur. The DON or designee will complete rounds and review bathing documentation to ensure compliance with care plans. Random audits will be completed 4 times weekly for 4 weeks, then 2 times weekly for 8 weeks. Identified concerns will be corrected at the time identified, as possible &amp; referred to DON for resolution. Results of the rounds will be presented in the facility QAPI meeting for three months (or longer as necessary) beginning in February, with any identified negative trends addressed through system modification and staff education as appropriate 5.) Date Corrective action will be completed: February 6, 2018</td>
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### Statement of Deficiencies and Plan of Correction

#### (X1) Provider/Supplier/CLIA Identification Number:
135098

#### (X2) Multiple Construction
- A. Building ________________________
- B. Wing ___________________________

#### (X3) Date Survey Completed
12/18/2017

**Valley View Nursing & Rehabilitation**

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<td>respond to call lights in time to provide toileting assistance. The interested party stated staff sometimes took up to 30 minutes to respond to Resident #59's call light for toileting assistance. The interested party stated Resident #59 had called him/her multiple times upset about the lack of showers and incidents of incontinence when staff had not responded to her call light in time. The interested party stated the facility had not showered Resident #59 twice weekly and that the grievances about showers that he/she had filed with the facility were still not resolved. The interested party stated the facility informed him/her that it was short on staff, but were trying to hire additional staff. The interested party stated residents should not suffer because the facility did not have an adequate number of staff.</td>
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#### (X4) ID Prefix | TAG | Tag |
| F 677 |     |     |

3. Resident #68 was admitted to the facility on 11/12/13 with diagnoses that included osteoporosis and osteoarthritis.

A quarterly MDS assessment, dated 11/12/17, documented Resident #68 was cognitively intact and totally dependent on staff for bathing.

The ADL Care Plan, revised 8/8/16, documented Resident #68 required the assistance of 1 staff for bathing and showers.

An ADL Shower Documentation Survey Report for 8/1/17 through 12/14/17 documented Resident #68 was to receive showers on Wednesdays and Sundays, but did not on 8/6/17, 8/13/17, 8/20/17, 8/23/17, 8/30/17, 9/17/17, 9/24/17, 10/4/17, 10/8/17, 10/11/17, 10/22/17, 11/1/17, 11/5/17, 11/12/17, and 12/10/17. The Report documented Resident #68 was not...
4. Resident #197 was admitted to the facility on 3/30/17 with multiple diagnoses, including dementia.

The 6/27/17 quarterly Minimum Data Set assessment documented Resident #197 was moderately cognitively impaired and required 1 staff assistance for bathing.

The ADL care plan, dated 3/30/17, documented Resident #197 was to receive a bath or shower.
5. Resident #31 was admitted to the facility on 8/23/17 with multiple diagnoses that included neurogenic bladder, paraplegia, depression, and pressure ulcer.

The quarterly MDS assessment, dated 11/30/17, documented Resident #31 was alert, cognitively intact, and required extensive assistance— or was totally dependent on staff for cares.

The Activities of Daily Living (ADL) Care Plan, dated 8/23/17, documented Resident #31 required extensive assistance of 2 staff for personal hygiene and oral care. Staff were directed to brush the resident's teeth, clean the gums, and rinse her mouth with mouthwash each morning and at bedtime. Staff were also directed to provide catheter care every shift.

A November 2017 ADL flowsheet documented
Resident #31, who staff was to bathe each Tuesday and Saturday, was bathed 4 times in November. The December 2017 ADL flowsheet documented Resident #31 was bathed twice from 12/1/17 to 12/14/17.

A facility Grievance Report completed on 10/23/17 by Resident #31 documented the resident had not received a shower, bath, pericare, or catheter care from 10/19/17 through 10/23/17. Resident #31 requested repositioning every 2 hours "because if I am not repositioned, my [pressure ulcer] wound will not get any better."

The facility Grievance Investigation Report, dated 10/24/17, documented staff noticed cares were not provided, including pericare and catheter care. A "read and sign" inservice directed staff to complete pericare/catheter care every shift and to reposition the resident every 2 hours.

On 12/13/17 at 1:49 pm, Resident #31 stated she had to request personal care from staff, who were not providing those cares on a daily basis. Resident #31 stated she was worried about contracting an infection from her indwelling urinary catheter; staff did not provide her with hand hygiene before meals; she was provided 3 showers between 11/6/17 and 12/10/17; staff did not provide a washcloth to wash her face unless she asked for it; and oral hygiene had not been provided for "weeks." Resident #31 stated, "There are days I look forward to because I know who is going to be here and I will get good care."

On 12/15/17 at 9:38 am, CNA #18, who worked as a shower aide, stated she was often
A sign titled, "ATTENTION NURSES AND CNAs!," posted by the staff timeclock in an area accessible to staff, residents, and visitors, documented, "When there is not enough staff to cover the floor, the shower aide needs to be the last person to be pulled to the floor. The expectation is the first floor run on 3 aides and 4 on the second floor before we 'tap' our other resources. If we don't have enough staff to cover this, pull one or both restorative aides to the floor first. If the shower aides must get pulled to the floor, we all must pitch in to make sure the showers get done for the day. Residents and Families are complaining about the lack of bathing and we have residents developing skin issues because they are not receiving showers for up to 2 weeks at a time. Per regulations, EACH RESIDENT MUST RECEIVE AT LEAST ONE SHOWER PER WEEK. If we aren't providing this, we are not compliant with our regulations." The posting was signed by the Director of Nursing and dated 8/30/17.

On 12/15/17 at 5:48 pm, the Assistant Director of Nursing stated the sign's reference to 1 shower per week was "our interpretation of the [federal] regulation."
**F 677** Continued From page 37

6. Similar findings regarding lack of bathing were true for Resident #37 and Resident #51.

On 12/15/17 at 11:39 am, the ADON stated when staff called off sick, the facility first reassigned restorative nursing aides and then bath aides to general CNA duties. The ADON stated she was aware residents did not receive adequate bathing due to the facility's lack of sufficient staffing.

**F 679** Activities Meet Interest/Needs Each Resident

CFR(s): 483.24(c)(1)

§483.24(c) Activities.
§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, it was determined the facility failed to ensure there was an ongoing activity program to meet individual resident needs. This was true for 1 of 26 residents (#31) sampled for quality of life concerns and created the potential for residents to become bored or depressed when not provided with meaningfully engagement throughout the day. Findings include:

Resident #31 was admitted to the facility on 8/23/17 with multiple diagnoses, including

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<td>§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on observation, interview, and record review, it was determined the facility failed to ensure there was an ongoing activity program to meet individual resident needs. This was true for 1 of 26 residents (#31) sampled for quality of life concerns and created the potential for residents to become bored or depressed when not provided with meaningfully engagement throughout the day. Findings include:</td>
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<td>Resident #31 was admitted to the facility on 8/23/17 with multiple diagnoses, including</td>
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### Summary Statement of Deficiencies

1. **Resident #31**
   - **Minimum Data Set Assessment (MDS)** dated 8/30/17 documented that Resident #31 was alert, cognitively intact, had no range of motion (ROM) impairment to her upper extremities, and required only set-up assistance for eating.

2. **Activity Program**
   - The 9/11/17 Activity Care Plan documented that Resident #31 did not participate in the facility's Activity program due to physical limitations and did not wish to participate in facility activities.

3. **On 12/13/17** at 1:48 pm, Resident #31 stated she was bedbound and did not attend activities. She stated her family brought her adult coloring books and pencils, but no pencil sharpener. Resident #31 stated the only activity person she had seen was a staff member who delivered mail, and noted, "There has been no offer of crafts. I am totally left in the dark, makes me feel left out and depressed. [The staff] don't have enough care to involve everyone."

4. **On 12/14/17** at 10:28 am, the Activity Director (AD) stated Resident #31 was provided activities in her room, including a DVD player, movies, books, and coloring books. Activities staff members stated Resident #31 received a good amount of mail and packages, which they assisted her with opening. When asked if they spent time just visiting with Resident #31 in her room, they stated, "No."

5. **On 12/15/17** at 9:22 am, Resident #31 stated having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:
   - All residents that are bedbound/unable to attend group activities will have their plans of care reviewed and updated to reflect resident's interests, preferences and needs on or before 2/06/18.

6. **What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.**
   - Activity staff will review resident participation in activities program, this look back will include independent, group and 1:1 activities. This review will occur weekly for 1 month starting on 1/17/18 and ending on 2/21/18.

7. **Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur.**
   - Activity Director will meet with ED monthly to review notes of monthly meeting to ensure all resident activities needs being met. Activities care plans will be part of IDT care plan audit beginning the week of 1/15/18. IDT will audit 5 resident plans of care weekly for 4 weeks, then audit 2 resident care plans per week for 8 weeks to identify discrepancies between the care plan and resident performance.

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**Summary of Corrective Actions**

- **F 679**
  - Continued From page 38
  - Neurogenic bladder, diabetes mellitus, paraplegia, depression, and a healing pressure ulcer.

- **F 679**
  - Having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.

- **F 679**
  - All residents that are bedbound/unable to attend group activities will have their plans of care reviewed and updated to reflect resident's interests, preferences and needs on or before 2/06/18.

- **What systemic change you will make to ensure that the deficient practice does not recur.**
  - Activity staff will review resident participation in activities program, this look back will include independent, group and 1:1 activities. This review will occur weekly for 1 month starting on 1/17/18 and ending on 2/21/18.

- **Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur.**
  - Activity Director will meet with ED monthly to review notes of monthly meeting to ensure all resident activities needs being met. Activities care plans will be part of IDT care plan audit beginning the week of 1/15/18. IDT will audit 5 resident plans of care weekly for 4 weeks, then audit 2 resident care plans per week for 8 weeks to identify discrepancies between the care plan and resident performance.

- **Date Corrective action will be completed.**
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<th>ID</th>
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<th>COMPLETION DATE</th>
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<tr>
<td>F 679</td>
<td>Continued From page 39 she would like to be offered the same activities offered to other residents in the facility, including arts and crafts. Resident #31 stated she was tired of watching TV, movies, and coloring, and wanted the opportunity to participate in other activities. On 12/15/17 at 4:28 pm, the AD stated Resident #31 did not meet the need for one-to-one activity, and noted, &quot;She is cognitively alert, able to socialize, we provide word find books.&quot; When told Resident #31 would like to participate in the facility's activities program, including arts and crafts, the AD stated Resident #31 could not participate in some activities offered to other residents, including a project requiring the use of a hot glue gun, for example. The AD stated the facility provided Resident #31 with an adequate activity program.</td>
<td>F 679</td>
<td>completed: February 6, 2018</td>
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<td>F 686</td>
<td>Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)</td>
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<td>SS=D</td>
<td>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:</td>
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Continued From page 40

Based on observation, staff interview, and record review, it was determined the facility failed to consistently implement the plan of care for pressure ulcer prevention for 2 of 2 sample residents (#51 and #89) reviewed for pressure ulcers. The failure created the potential for the residents to develop pressure ulcers to the heels and/or coccyx. Findings include:

1. Resident #89 was admitted to the facility on 11/3/17 with multiple diagnoses, including Type II diabetes mellitus, difficulty walking and generalized weakness.

   Resident #89’s care plan documented the potential for skin impairment and a history of pressure ulcer to the sacrum/coccyx area as a concern on 11/3/17. Interventions included heel elevation with off-loading boots when in bed, initiated 11/3/17.

   Resident #89’s recapitulated physician orders documented a 12/7/17 order for off-loading boots at all times while in bed every shift as a preventative care.

   Resident #89 was observed in bed without off-loading boots in place and the heels not elevated as follows:

   * On 12/12/17 at 9:30 am, the resident was asleep on his back.
   * On 12/13/17 at 10:12 am, the resident was asleep on his back. At 10:15 am, Certified Nursing Assistant (CNA) #4 and CNA #5 assisted the resident to use the restroom and then into a wheelchair. CNA #5 said the resident was

F 686 Tx/Svcs to prevent/heal pressure ulcers

1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

   Resident #89 no longer resides in the facility, unable to correct deficient practice

   Resident #51 Treatment Administration Record was reviewed and residents skin was evaluated by the facility certified skin/wound nurse. The resident’s orders and plan of care were updated & staff was in serviced regarding the use of Resident #51’s personal recliner.

2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

   Facility residents with a current or a history of pressure ulcers, residents with MD ordered devices to protect the skin and residents with care planned skin issues were audited by the DON or designee. This audit ensured that the skin preventative device is being used as per resident’s plan of care. Identified concerns were corrected at the time identified with appropriate staff education provided as indicated.

3. What measures will be put in place or what systemic change you will make to

   Resident #51's personal recliner.
F 686 Continued From page 41

wearing only socks prior to getting him out of bed and that his heels were not elevated while he was in bed. CNA #5 found a pair of padded heel protectors in the resident's closet.

* On 12/13/17 at 2:08 pm, the resident was asleep on his back.

* On 12/13/17 2:58 pm, the resident was still asleep on his back when CNAs #9 and #16 went in to check and change his incontinence brief and reposition him. The resident's heels were in contact with the mattress and CNA #9 said heel protectors and/or a heel lift pad were not in place. Both of the resident's heels were intact and a 1 centimeter (cm) by 1/2 cm red area was observed at the inner left buttock near the coccyx during incontinent care.

On 12/14/17 at 10:35 am, the resident was observed in bed wearing padded heel protectors on both feet.

2. Resident #51 was readmitted to the facility on 7/12/17 with diagnoses that included urinary retention, urinary tract infection, diabetic cystopathy, and sepsis.

A significant change MDS assessment, dated 10/27/17, documented Resident #51 was cognitively intact, required extensive assistance of 1 staff for toileting, extensive assistance of 2 staff for transfers and bed mobility, was at high risk of developing pressure ulcers, and had a pressure reducing device for her bed and chair. The MDS did not document the resident was on a repositioning schedule.

ensure that the deficient practice does not recur.

Nursing staff were reeducated by the DON or designee on how to identify protective devices in use for each resident, expectation for the placement of device per plan of care and provided instruction on how to identify issues/concerns related to pressure ulcer treatment.

4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur.

The IDT will complete rounds to audit the use of protective devices, skin prevention measures to ensure compliance with care plans. Rounds will be completed 3 times weekly for 4 weeks, then 2 times weekly for 8 weeks. Identified concerns will be corrected at the time identified, as possible, with appropriate staff education provided as indicated.

Results of rounds will be presented in the facility QAPI meeting for three months (or longer as necessary) beginning in February, with any identified negative trends addressed through system modification and staff education as appropriate.

5.) Date Corrective action will be completed: February 6, 2018
### F 686

Continued From page 42

A Potential Skin Impairment Care Plan, revised 11/2/17, documented staff were to assist Resident #51 with repositioning and offloading as needed 2-3 times each shift. The care plan documented staff were to encourage Resident #51 to limit her time in a recliner to 1.5 - 2 hours at a time.

A physician's order, dated 10/27/17, documented staff were to limit Resident #51's time in a recliner to 1.5 - 2 hours at a time.

Resident #51's Treatment Administration Record (TAR) for 11/1/17 through 12/14/17 documented nursing staff limited Resident #51’s time in the recliner.

Resident #51 was observed sitting in a recliner for longer than 2 hours at a time on 12/11/17 from 2:28 pm - 4:55 pm; on 12/13/17 from 10:15 am to 4:24 pm; and on 12/14/17 from 9:03 am to 11:16 am, when a staff member assisted her to a wheelchair for lunch.

On 12/13/17 at 10:58 am, Resident #51 stated she preferred to sit in her recliner the majority of the day.

On 12/15/17 at 10:15 am, CNA #19 stated Resident #51 typically arose and prepared for the day between 6:30 am and 7:30 am. CNA #19 stated Resident #51 remained in her wheelchair until she was through with breakfast, and then preferred to sit in her recliner in her room until lunch. CNA #19 stated Resident #51 typically remained in the recliner until dinner, as well, and did not participate in many activities as she...
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BUILDING

PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

135098

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

MULTIPLE CONSTRUCTION
B. WING

DATE SURVEY
COMPLETED

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

MULTIPLE CONSTRUCTION
B. WING

DATE SURVEY
COMPLETED

PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1140 NORTH ALLUMBAUGH STREET

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391

PRINTED: 07/09/2018

12/18/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1140 NORTH ALLUMBAUGH STREET

BOISE, ID 83704

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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F 686

Continued From page 43

preferred to read books in her recliner. CNA #19 was unaware of any positioning restrictions placed on Resident #51's recliner time, and stated she was only aware of a 2 hour repositioning limit while Resident #51 was in bed.

On 12/15/17 at 10:19 am, CNA #7 provided an identical description of how Resident #51 spent the day in her recliner reading books with brief breaks for meals. CNA #7 stated she was unaware of any positioning restrictions placed on Resident #51's recliner time.

On 12/15/17 at 10:41 am, LPN #1 stated Resident #51 napped often throughout the day. LPN #1 stated she was not sure if the resident was on a repositioning schedule, but that would be information the resident's CNAs would know and implement.

On 12/15/17 at 12:28 pm, the Assistant Director of Nursing (ADON) stated staff should reposition Resident #51 at least every 2 hours, regardless of the resident's location. The ADON stated she was not aware of any limits placed on the time Resident #51 spent in the recliner or whether the resident refused alternative seating arrangements. The ADON stated staff should be aware of any time limits to the resident's recliner time and document those times Resident #51 refused to reposition or sit in another location.

F 688

Increase/Prevent Decrease in ROM/Mobility

CFR(s): 483.25(c)(1)-(3)

§483.25(c) Mobility.

§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in
### F 688 Activities Daily Living

This requirement was not met as evidenced by the determination that the facility failed to implement a restorative nursing program for resident #11 and created the potential for resident #11 to experience a decline in Range of Motion (ROM). Findings include:

1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

Per record review for resident #11, the facility records the facility provided a copy of December 2017 RNA program to the survey team. Resident 11 had two RNA programs in place: PROM and exercise for both upper and lower extremities from Dec 1 to December 10, 2018. December 10, 2018 resident was admitted to the facility.
### Summary Statement of Deficiencies

**F 688**

Continued From page 45 consisting of passive ROM.

The 9/15/17 quarterly MDS assessment documented the resident did not have a functional ROM limitation in the upper or lower extremities and no RNP services were provided.

Resident #11's care plan documented she was at risk for not having her needs met due to paralysis. The care plan was initiated 6/21/16, revised 12/9/16, and included a 3/17/17 intervention for RNP. RNP interventions included passive ROM to the lower extremities 6-7 days a week for 15 minutes, and passive/active ROM to the upper extremities 6-7 days a week for 15 minutes.

Resident #11's clinical record documented staff provided passive ROM to the lower extremities 2-5 times per week from July through November 2017, and active/passive ROM to the upper extremities 0-5 times per week during the same time period. The facility did not provide RNP documentation for December 2017.

On 12/14/17 at 10:24 am, an Interested Party said Resident #11's RNP program was frequently not provided because restorative staff were not always available.

On 12/15/17 at 4:42 pm, the Director of Nursing (DON) reviewed Resident #11's RNP documentation and said there were several "holes" for multiple weeks. The DON said "holes" meant RNP did not occur. The DON stated RNP may not have occurred if the restorative nursing assistant was not available.

### Provider's Plan of Correction

F 688

Hospital for Acute encephalopathy secondary to unspecified etiology. Upon readmission on 12/15/17 resident had physician orders for Physical Therapy, Occupational Therapy and Speech Therapy. Since 12/15/2017 resident has been receiving skilled therapy and upon discharge of skilled therapy the Rehab Manager has indicated that a Restorative Nursing Program will be established. Unable to provide corrective action for the days resident did not receive RNA program from July to December.

2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

Residents were evaluated by the DON or designee on or before 2/6/18, for need of a restorative program. If determined that a resident would benefit from a RNA program than a program was established and plan of care updated. If a resident already receiving restorative program than program reviewed and revised as indicated and plan of care updated as warranted.

Therapy department will continue to routinely screen facility residents quarterly, if there is a significant change in condition and as needed and follow up as indicated with PT/OT/ST or establish a RNA program.

3.) What measures will be put in place or
what systemic change you will make to ensure that the deficient practice does not recur.

Nursing staff have been educated by DON or designee on or before 2/6/18 regarding the requirements to provide RNA programs as found in CFR 483.24 (a)(1)(b)(1)-(5)(i)-(iii) and hot to identify issues/concerns related to RNA programs.

4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur.

Beginning the week of 2/4/18 DON or designee will complete audit to ensure compliance with CFR 483. 24 (a)(1)(b)(1)-(5)(i)-(iii). Audit will be done on five residents weekly for 4 weeks, then 2 residents weekly for 8 weeks. Identified concerns will be corrected at the time identified, as possible & referred to DON for resolution.

Results of the audits will be presented in the facility QAPI meeting for three months (or longer as necessary) beginning in February, with any identified negative trends addressed through system modification and staff education as appropriate.

5.) Date Corrective action will be completed: February 6, 2018
F 689 Continued From page 47

SS=G CFR(s): 483.25(d)(1)(2)

§483.25(d) Accidents. The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and
§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:

Based on observation, record review, and interview, it was determined the facility failed to provide adequate supervision to meet resident needs. This was true for 3 of 4 residents (#s 7, 37 & 197) reviewed for supervision and accidents. Resident #7 was harmed when staff failed to provide adequate supervision while the resident was in a wheelchair; the resident fell from the wheelchair and fractured her left femur. Residents #37 and #197 were at risk for harm from accidents due to inadequate supervision and an inappropriately inflated air bed. Findings include:

1. Resident #7 was readmitted to the facility on 9/3/17 with multiple diagnoses, including Parkinson's disease and dementia.

The 9/10/17 admission Minimum Data Set (MDS) assessment documented Resident #7 was moderately cognitively impaired, required extensive assistance of 1 staff for locomotion, frequently incontinent of bladder, and totally dependent on 2 staff for toileting.

A mobility care plan, dated 8/29/17, documented
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<th>ID PREF/ TAG</th>
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<td>F 689</td>
<td>Continued From page 48</td>
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<td>Resident #7 required the extensive assistance of 1 staff to propel her wheelchair both on- and off the unit.</td>
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<td>A bowel and bladder elimination care plan, dated 8/29/17, documented Resident #7 required the assistance of 2 staff for toileting.</td>
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<td>A risk for falls care plan, dated 8/29/17, documented Resident #7 was on a fall prevention program and staff were to encourage the resident to be in a common area or activity when in a wheelchair.</td>
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<td>A Physician's Order, dated 12/6/17, documented Resident #7 was discharged from hospice services.</td>
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<td>A 12/7/17 Occupational Therapy (OT) care plan documented Resident #7 used a high back wheelchair when out of bed that she was unable to propel herself.</td>
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<td>A 12/7/17 Physical Therapy (PT) daily treatment note and assessment documented Resident #7 used a high-back recliner wheelchair, but was provided a standard wheelchair when the high-backed model was returned to the hospice provider. The PT note and assessment did not document the resident was assessed for safety and locomotion in the standard wheelchair.</td>
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<td>A bladder and bowel report documented Resident #7's incontinent brief was changed on 12/9/17 at 1:14 am and 3:48 am for bladder and bowel incontinence respectively.</td>
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<td>A Nursing Note, dated 12/9/17 at 2:05 pm, therapy for wheelchair fit and safety, and due to fall with left femur fracture, resident has been provided with a high back wheelchair with elevating left leg and standard right leg rests to provide support and safety due to left femur fracture. Facility is unable to assess whether a standard wheelchair is safe and appropriate for resident #7 due to resident #7's fracture that necessitated a return to a high back wheelchair with elevating leg rest. Resident was assessed by nursing on 12/9/2017 for risk for falls and Fall Assessment and care plan have been reviewed and updated as appropriate. Resident #37 was assessed by nursing for risk for falls, and fall assessment and care plan have been updated as appropriate. Facility is unable to complete Fall Assessments for previous falls that did not have Fall Assessments completed, as Fall Risk Assessments have been completed subsequent to the missing evaluations. Resident #197 has discharged from the facility, unable to complete any corrective action. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. The residents were assessed for any issues such as fall risks, incidents/accidents, care needs, and were</td>
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Documented resident #7 had been discovered on the floor on her left hip wearing "soaked through clothing." The resident said she had leaned forward to hold onto a railing at the time of the fall. A post-fall assessment determined the resident was not in pain.

A 12/12/17 OT treatment note documented resident #7 experienced an increase in pain to the left knee and hip while standing when a mechanical sit-to-stand lift was used.

A radiology report, dated 12/12/17, documented resident #7 had a fractured left femur.

A 12/13/17 Physician's Order documented resident #7 was to have a left knee immobilizer at all times related to the leg fracture.

A fall investigation report, dated 12/14/17, documented resident #7 fell from her wheelchair on 12/9/17 in the hallway near her room while trying to pull herself towards her room with the handrail. The investigation documented the resident had been incontinent of bladder and staff had been educated to offer the resident a bedpan and toileting. The investigation documented the resident had not identified any other issues which could have caused the fracture and that the fracture was likely sustained at the time of the fall.

On 12/12/17 at 2:01 pm, a portable X-ray machine and standard wheelchair were observed in resident #7's room.

On 12/13/17 at 10:01 am, resident #7 was observed in bed with an immobilizer to her left evaluated for fall risk using the facility Fall Risk Assessment on or before 2/6/18. Fall prevention care plans for residents who scored 10 or greater on the Fall Risk Assessment were reviewed by the IDT for adequate and appropriate fall prevention interventions, including review of resident routines and schedules as appropriate.

The residents who have air mattresses have been assessed by the skin and wound nurse for proper inflation settings on or before 2/6/18. Proper settings have been added to documentation for licensed and non-licensed nursing staff to check each shift to ensure the setting is correct. Care plans for all residents with air mattresses have been audited to ensure correct settings are care planned. Appropriate staff education provided at the time of audits.

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.

Staff were reeducated before 2/6/18 by DON or designee on the expectations for supervision and how to identify resident issues/concerns related to this requirement.

IDT will review newly admitted residents for fall risk using the facility Fall Risk Assessment. IDT will review care plans
Continued From page 50

F 689

The resident said she had fallen the previous week when grabbing a handrail in an attempt to get to the "next room." Resident #7 said she did not remember having pain at the time of the incident, but had experienced some pain since, which increased while she received therapy on 12/12/17.

On 12/13/17 at 3:09 pm, CNA #12 (Certified Nurse Assistant) said Resident #7 had a recent wheelchair change and was incontinent of bowel and bladder. CNA #12 said Resident #7's care plan documented the resident was not to be left alone and was to be supervised while in her wheelchair, but a lack of staff prevented the facility from providing ongoing supervision while Resident #7 was in the wheelchair.

On 12/13/17 4:06 pm, Resident #7's Interested Party said the resident received the standard wheelchair upon discharge from hospice the previous week. The Interested Party stated Resident #7 had fallen from the wheelchair observed in Resident #7's room on 12/12/17.

On 12/14/17 9:37 am, LPN #2 (Licensed Practical Nurse) stated Resident #7's wheelchair had been recently changed and that staff were to "keep her within sight" when she was in the wheelchair because the resident was at risk for falls.

On 12/14/17 at 4:08 pm and 12/15/17 at 11:48 am, the DON (Director of Nursing) said Resident #7 was on the facility's fall prevention program because she was at "high risk" for falls. The DON stated the resident was "wet" at the time of the fall, and frequently experienced urinary incontinence. The resident said she had fallen the previous week when grabbing a handrail in an attempt to get to the "next room." Resident #7 said she did not remember having pain at the time of the incident, but had experienced some pain since, which increased while she received therapy on 12/12/17.

On 12/13/17 at 3:09 pm, CNA #12 (Certified Nurse Assistant) said Resident #7 had a recent wheelchair change and was incontinent of bowel and bladder. CNA #12 said Resident #7's care plan documented the resident was not to be left alone and was to be supervised while in her wheelchair, but a lack of staff prevented the facility from providing ongoing supervision while Resident #7 was in the wheelchair.

On 12/13/17 4:06 pm, Resident #7's Interested Party said the resident received the standard wheelchair upon discharge from hospice the previous week. The Interested Party stated Resident #7 had fallen from the wheelchair observed in Resident #7's room on 12/12/17.

On 12/14/17 9:37 am, LPN #2 (Licensed Practical Nurse) stated Resident #7's wheelchair had been recently changed and that staff were to "keep her within sight" when she was in the wheelchair because the resident was at risk for falls.

On 12/14/17 at 4:08 pm and 12/15/17 at 11:48 am, the DON (Director of Nursing) said Resident #7 was on the facility's fall prevention program because she was at "high risk" for falls. The DON stated the resident was "wet" at the time of the fall, and frequently experienced urinary incontinence.

F 689

for residents who score 10 or greater, and implement fall prevention interventions as needed. Needs identified will be implemented at the time they are identified, or delegated to be addressed. Items delegated will be followed by the IDT until completion, and staff education will be provided about resident needs as indicated.

The newly ordered air mattresses will be reviewed by the skin and wound nurse for proper inflation settings. Settings will be added to documentation for licensed and non-licensed staff to check each shift to ensure correct settings. Care plans will be updated with correct settings as appropriate.

4. Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur.

The IDT will audit current and newly admitted resident progress notes, incident/accident reports, fall risk assessments for all identified falls, to ensure compliance with safety and accident prevention. Random audits will be completed 4 times weekly for 4 weeks, then 2 times weekly for 8 weeks. Identified concerns will be corrected at the time identified, as possible, with appropriate staff education provided as indicated.

Results of the documentation, incident
### F 689
Continued From page 51

Incontinence, which CNAs were to document into the resident's clinical record. The DON said she thought Resident #7 had been evaluated for the new wheelchair, and that the care plan directed staff to assist the resident with locomotion and keep her within view when she was in a wheelchair. The DON stated Resident #7 did not require one-to-one supervision, and that the hallway where the resident was found on the floor was considered a common area.

On 12/14/17 at 5:52 pm, OT #2 (Occupational Therapist) said Resident #7 was assessed for the new standard wheelchair on 12/7/17, however that evaluation did not assess the resident's ability to move about the facility in the wheelchair.

On 12/15/17 at 9:49 am and 12:17 pm, CNA #13 said she “thought” she changed Resident #7’s incontinence brief prior to lunch on 12/9/17. CNA #13 stated she assisted Resident #7 from the dining room to the hallway in the general area outside her room after lunch on 12/9/17. CNA #13 stated she entered another resident's room and that RN #3 and another nurse were in the hallway where she left Resident #7.

On 12/15/17 at 10:03 am, LPN #3 said she was not sure whether another staff member was in the hallway at the time Resident #7 fell from her wheelchair.

5. Date Corrective action will be completed: February 6, 2018

and accident and fall risk assessment audits will be presented in the facility QAPI meeting for 3 months (or longer as necessary) beginning in February, with any identified negative trends addressed through system modification and staff education as appropriate.
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<td>F 689</td>
<td></td>
<td></td>
<td>Continued From page 52 dementia and a history of falling.</td>
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<td>The 6/27/17 quarterly MDS assessment documented Resident #197 was moderately cognitively impaired and required extensive assistance of 1 staff for bed mobility.</td>
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<td>The risk for skin impairment care plan, dated 3/30/17, documented Resident #197 had been provided a specialty mattress.</td>
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<td>An 8/28/17 Nurses Note documented Resident #197 was found on the floor of her room with a large hematoma on her forehead.</td>
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<td>A fall investigation report, dated 8/29/17, documented Resident #197’s specialty air mattress was not set at the recommended setting, which led to the resident sliding off the bed and onto the floor.</td>
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<td>On 12/15/17 at 10:40 am, LPN #4 said Resident #197 had an airbed and preferred lying on her right side.</td>
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<td>On 12/15/17 at 10:52 am, the DON said Resident #197 fell out of bed due to an improper air mattress inflation setting.</td>
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3. Resident #37 was admitted to the facility on 9/30/17 with diagnoses that included dementia and fracture of the right femur.

A 9/30/17 Fall Risk Assessment documented Resident #37 was at high risk of falling.

A 10/7/17 admission MDS assessment
documented Resident #37 was severely cognitively impaired, required the extensive assistance of 2 staff for bed mobility, transfers, and toileting, and had experienced falls.

An At Risk for Falls Care Plan, revised 10/12/17, documented staff were to ensure Resident #37's call light, eyeglasses, water, television remote, and other commonly used items were within her reach. The care plan documented Resident #37's nightly routine consisted of going to bed between 9 pm and 10 pm; awaking at 2 am to 3 am; walking/eating a snack, and then returning to bed.

Additionally, the care plan documented Resident #37 was part of a fall prevention program that required staff to ensure the resident's bed was set at a marked height; non-skid strips were in place to the left side of the bed; the head of the resident's bed was elevated to 30 degrees; a locked wheelchair was positioned next to the bed; bilateral body pillows were in place; the resident was to be assisted to the toilet between 2:00 am and 3:00 am; staff were to offer toileting if the resident awoke during the night; and all devices and interventions were in place as ordered.

Resident #37's clinical record documented the resident experienced 8 unwitnessed falls between 10/4/17 and 12/9/17. The facility did not complete an investigation for one of these falls; a fall risk assessment for 4 of the 8 falls; or an assessment of the resident's daily routine until after the third fall.

Resident #37's Incident and Accident (I&A)
F 689 Continued From page 54

Reports documented the following:

* 10/4/17 - 12:45 am: Discovered on the floor following an unwitnessed fall from bed. The clinical record did not contain a completed fall risk assessment following the incident.

* 10/5/17 - 3:57 pm: Unwitnessed fall from bed while wearing a soiled incontinent brief. The clinical record did not contain a completed fall risk assessment or progress note related to the fall following the incident.

* 10/11/17 - 2:28 am: Unwitnessed fall from bed. The clinical record did not contain a completed fall risk assessment following the incident.

A 10/11/17 Social Services Review documented Resident #37 slept 4 hours at night and napped during daylight hours. A Social Service Evaluation was not completed until Resident #37 had experienced three falls at the facility.

A 10/11/17 Nurse's Note documented Resident #37's Interested Party stated the resident had sustained a fractured hip from a 2:30 am fall at a previous facility. The Nurse's Note documented facility staff would begin offering toileting assistance to Resident #37 between 12:00 am and 2:00 am, however this planned intervention was not proposed until after Resident #37 had experienced 3 falls at the facility.

On 10/29/17 at 2:49 am, Resident #37 experienced an unwitnessed fall from bed while wearing soiled incontinence brief. A Nurse's Note, dated 10/29/17 at 6:44 am, documented Resident #37 was "found sitting on the floor..."
Continued From page 55

saying, 'Help me, help me.' The facility did not complete an investigation for this fall and the clinical record did not contain a completed fall risk assessment following the incident.

* 11/8/17 - 3:27 am: Unwitnessed fall from bed. The resident was assisted into a wheelchair and brought to the nurses' station.

An 11/8/17 Interdisciplinary Note (IDT) documented each of Resident #37's safety devices and Falling Star interventions were in place at the time of the fall.

* 11/9/17 - 11:15 pm: Unwitnessed fall from bed. The resident was found with an incontinence brief around her ankles. Resident #37 was assisted into a wheelchair and brought to the nurses' station.

An 11/15/17 Nurse's Note documented an Interested Party, when contacted by the facility, stated Resident #37 routinely went to bed between 10:00 pm and 10:30 pm, walked between 2:00 am and 3:00 am, and spent the remainder of the night in a common area recliner. The Note documented Resident #37 spent long periods of time sleeping in a recliner during the day, and that a nurse discussed placing an alarm on Resident #37 while in bed. The Interested Party's information concerning the recliner was not included on Resident #37's care plan or fall prevention program.

An 11/16/17 Social Services Note documented the facility moved Resident #37 to a new room closer to a nurse's cart and closer to nursing aides for safety.
F 689 Continued From page 56

* 12/9/17 - 3:20 pm: Unwitnessed fall in the resident's room while attempting an unassisted transfer from a wheelchair.

Resident #37's Fall Care Plan, revised 12/11/17, documented staff were to continue the at-risk interventions and complete neurological assessments.

On 12/11/17 at 2:37 pm, Resident #37's bed was observed with bilateral upper half siderails in the upraised position and body pillows on the lower portion of the bed. Resident #37 grasped the right siderail and unsuccessfully attempted to reposition herself on her bed. Resident #37 then attempted to swing her legs out of the bed and called out, "Help, help, help, help." CNA #11, who responded to the resident's request for help, began lowering Resident #37's bed and placed a draw sheet under the resident. Resident #37 attempted to swing her legs off the bed again, and stated her back hurt and she needed to get up. CNA #8 entered the room and the two CNAs used the draw sheet to reposition Resident #37 in the bed. Resident #37 stated she felt better after the repositioning.

On 12/12/17 from 11:00 am to 11:32 am, Resident #37 was observed in a wheelchair in the television (TV) room. No staff were present during the observation as the resident attempted to retrieve her eyeglasses on the floor in front of her. At 11:32 am, the DON picked up Resident #37's eyeglasses and placed them on her face.

On 12/13/17 at 9:53 am, Resident #37 was observed unattended in a wheelchair watching
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 135098

**B. WING _____________________________**

**DATE SURVEY COMPLETED:** 12/18/2017

**NAME OF PROVIDER OR SUPPLIER:** VALLEY VIEW NURSING & REHABILITATION

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

1140 NORTH ALLUMBAUGH STREET
BOISE, ID  83704

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**OMB NO. 0938-0391**

**PRINTED:** 07/09/2018

**FORM APPROVED:**

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**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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- **F 689**
  - Continued From page 57
  - Television in the TV room with no staff present. At 9:58 am, CNA #5 approached the resident and asked if she wanted to go to bed. Resident #37 stated she was tired, but wanted to stay where she was. Resident #37 then declined CNA #5’s offer of a snack and CNA #5 left the room. At 10:20 am, while still in the TV room with no staff present, Resident #37 began leaning forward and then rocking in her wheelchair with only her toes in contact with the floor. At 10:28 am, Resident #37 declined the DON’s offer of fluids. At 10:49 am, Resident #37 remained in the TV room with no staff present.

- **On 12/15/17 at 10:54 am,** the Assistant Director of Nursing (ADON) stated:
  - * All residents were to have individualized fall care plans
  - * Staff were to complete a fall risk assessment following all falls
  - * She would attempt to locate the missing fall risk assessments related to Resident #37’s unwitnessed falls on 10/4/17, 10/5/17, 10/11/17, and 10/29/17

- **F 690**
  - Bowel/Bladder Incontinence, Catheter, UTI
  - **CFR(s):** 483.25(e)(1)-(3)
  - **§483.25(e) Incontinence.**
  - **§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.**
  - **§483.25(e)(2) For a resident with urinary incontinence, based on the resident’s**
### F 690

**Continued From page 58**

Comprehensive assessment, the facility must ensure that-

(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;

(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and

(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

**§483.25(e)(3)** For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.

This **REQUIREMENT** is not met as evidenced by:

Based on observation interview, and record review, it was determined the facility failed to ensure residents' urinary care needs were met. This was true for 3 of 6 residents (#7, #51, and #59) sampled for decreased bladder control, Urinary Tract Infections (UTIs), and indwelling urinary catheters. As a result:

- a) Resident #51 was harmed when indwelling urinary catheter care was not consistently provided and the resident developed recurrent UTIs.

**F 690 Bowel/Bladder Incontinence, Catheter, UTI**

1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

Resident 7 has been reevaluated using the Bowel and Bladder assessment and her plan of care has been updated to

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<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tr>
<td><strong>F 690</strong></td>
<td>Continued From page 58 comprehensive assessment, the facility must ensure that- (i) A resident who enters...</td>
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<td><strong>§483.25(e)(3)</strong> For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure...</td>
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<td>This <strong>REQUIREMENT</strong> is not met as evidenced by:</td>
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<td>Based on observation interview, and record review, it was determined the facility failed to ensure residents' urinary care needs were met. This was true for 3 of 6 residents (#7, #51, and #59) sampled for decreased bladder control, Urinary Tract Infections (UTIs), and indwelling urinary catheters. As a result:</td>
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<td>a) Resident #51 was harmed when indwelling urinary catheter care was not consistently provided and the resident developed recurrent UTIs.</td>
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<td>F 690</td>
<td>Continued From page 59</td>
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<tr>
<td>b)</td>
<td>resident #59 was harmed when she did not receive consistent pericare and developed a UTI.</td>
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<td>c)</td>
<td>Resident #7 had the potential for harm when the facility failed to complete a bladder retraining program after determining the resident was an appropriate candidate.</td>
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<td>Findings include:</td>
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<tr>
<td>1.</td>
<td>resident #51 was readmitted to the facility on 7/12/17 with diagnoses that included urinary retention, UTI, diabetic cystopathy, and sepsis.</td>
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<td>A significant change Minimum Data Set (MDS) assessment, dated 10/27/17, documented Resident #51 was cognitively intact, had an indwelling (Foley) urinary catheter, and required the extensive assistance of 1 staff for toileting.</td>
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<td>The Catheter and UTI Care Plan, revised 7/12/17, documented Resident #51 experienced chronic recurrent UTIs, had a Foley catheter, and tested positive for colonized Extended Spectrum Beta Lactamase (ESBL).</td>
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<tr>
<td>a.</td>
<td>Resident #51 experienced multiple UTIs requiring antibiotic therapy.</td>
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<td>Urinalysis results from 7/5/17, 8/22/17, 9/25/17, and 10/20/17 document Resident #51’s urine appeared cloudy and contained blood, other proteins, mucous, and bacteria.</td>
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<td>Resident #51’s culture and sensitivity (C&amp;S) results were requested for each of the urinalysis results. The facility provided only the 9/25/17 and 10/20/17 results, which documented the presence of Escherichia Coli (E. coli) (9/25/17) and Candida Albicans (10/25/17).</td>
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<td>F 690</td>
<td>accurately reflect the required assistance and staff.</td>
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<td>Resident 59 no longer resides in the facility, unable to provide corrective action for the deficient practice.</td>
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<td>Resident 51: Per review of the 2567 documentation the facility is unable to determine why the surveyor requested documentation of urine cultures for this resident from the UA obtained 7/5/17 and 8/22/17 were not produced. This documentation is present and readily available in the resident’s PCC medical record.</td>
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<td>Resident 51 has Type 1 DM, Urinary retention managed with chronic indwelling catheter, failure to thrive, chronic UTIs Per culture and sensitivity results review &quot; 7/5/17 order for UA for C&amp;S obtained, o antibiotic ordered on 7/5/17 r/t flank pain, N/V. Per progress note 7/5/17 by LPN, the resident received a dose of antibiotic Bactrim at 2056. Per MAR a second dose was given 7/6/17 at 0720. i Resident continued to decline in her overall condition and was discharged to the hospital on 7/6/17 at 0958. o Final Culture received 7/7/17 and noted mixed flora, resident did not readmit until 7/12/17. &quot; Per progress notes from 8/22/17 the resident was experiencing fluctuating blood sugars, NP notified and ordered UA for C&amp;S. o Urinalysis results were discussed with NP on 8/25/17 and no new orders</td>
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Summary Statement of Deficiencies

A 7/6/17 Physician’s Order directed staff to treat Resident #51’s UTI with Bactrim (antibiotic) twice daily for five days. Medication Administration Records (MAR) for 7/1/17 through 7/14/17 documented Resident #51 received one dose of Bactrim on 7/6/17; the MAR did not document any additional doses of Bactrim were administered to Resident #51 during this time period.

An 8/28/17 Physician’s Order directed staff to treat Resident #51’s UTI with Macrobid, 100 milligrams (mg), twice daily for seven days. The antibiotic was initiated 6 days after the 8/22/17 urinalysis results were shared with the facility.

A 9/30/17 Physician’s Order directed staff to treat Resident #51’s UTI with Nitrofurantion, 100 mg, twice daily for seven days. The antibiotic was initiated 5 days after urinalysis lab results were shared with the facility.

b. Catheter care was not consistently provided.

Resident #51’s Catheter and UTI Care Plan, revised 7/12/17, documented staff were to provide catheter care at least three times daily.

Foley Catheter Care Flowsheets from 9/1/17 through 12/14/17 documented Resident #51 received catheter care twice daily on 9/9/17, 9/10/17, 10/6/17, 10/13/17, 10/14/17, 10/16/17, 10/17/17, 10/24/17, 10/25/17, 10/31/17, 11/8/17, 11/11/17, 11/22/17, 11/27/17, 12/2/17, and 12/6/17.

Unable to provide any corrective action for prior UTI s, per McGreer’s criteria residents UTI s were treated appropriately and per documentation interventions were timely. Unable to correct any missing catheter flowsheet.

Per McGeer Criteria for Long Term Care Surveillance UTI in a resident WITH a catheter resident must have BOTH criteria present and states a UTI is diagnosed when there are localizing genitourinary signs and symptoms and a positive urine CULTURE result with at least 105 cfu/mL of an organism(s).
On 12/15/17 at 12:28 pm, the Assistant Director of Nursing (ADON) stated staff were to perform catheter care minimally once per shift, or three times a day. The ADON stated Resident #51’s UTI attributed to E.coli was "most likely" due to a lack of proper peri-care. The ADON stated a lack of staffing "may have" contributed to the facility's failure to provide the resident with catheter care as care planned and to the development of her recurrent UTIs.

2. Resident #59 was admitted to the facility on 10/25/17 with diagnoses that included chronic kidney disease, personal history of UTIs, chronic cystitis, and irritable bowel syndrome. An initial MDS assessment, dated 11/1/17, documented Resident #59 was cognitively intact, frequently incontinent, and required the extensive assistance of 1 staff for toileting.

The Bowel and Bladder Elimination Care Plan, dated 10/25/17, documented Resident #59 required extensive assistance from 2 staff with toilet transfers, incontinence product change, and peri-care. The care plan documented Resident #59 was to receive scheduled toileting and that staff were to provide pericare after each episode of incontinence.

A 12/14/17 Physicians Order directed staff to administer a Rocephin antibiotic injection to Resident #59 once daily for three days. The MAR from 12/1/17 through 12/14/17 MAR documented staff administered only 1 of the 3 Rocephin antibiotic injections (12/14/17) ordered by the physician to treat Resident #59’s UTI.

F 690 documentation.

2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?

The DON or designee reevaluated the residents with the Bowel and Bladder assessment. Once reevaluated the residents plan of care was reviewed and updated as needed to reflect the residents individualized bowel and bladder care needs and staff education was provided as identified.

3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.

Licensed nursing staff were reeducated and provided instruction on expectations and completion of the Bowel and Bladder evaluation and how to identify issues/concerns related to incontinence.

CNA’s were reeducated by the DON or designee on the expectations and completion of the Point of Care documentation areas Personal Hygiene, Toileting, Indwelling Catheter Care, and how to identify issues/concerns related to this requirement.

4.) Indicate how the corrective action(s) will be monitored to ensure the corrective
Resident #59's urinalysis result from 12/10/17 documented her urine was cloudy and tested positive for red- and white blood cells, as well as E.coli bacteria.

On 12/12/17 at 9:30 am, CNA #5 was observed responding to Resident #59's call light. The resident stated she needed to use the toilet. CNA #5 stated she would assist Resident #59 shortly, turned the call light off, and left the room. At 9:43 am, Resident #59 was observed sitting in her room without clothing or undergarments from her waist to her feet. Resident #59 stated she had taken her clothes off in response to an episode of incontinent diarrhea and did not want to sit in her feces. The surveyor notified the CNAs that the resident required assistance. CNA #5 and CNA #6 entered the room to assist Resident #59 with peri-care. CNA #5 donned gloves and provided pericare to Resident #59. CNA #5 then took her gloves off and dressed Resident #59 in undergarments without first performing hand hygiene. At 9:55 am Resident #59 states she was not accustomed to sitting in her own excrement, which was "embarrassing" and caused her to "feel worthless."

On 12/12/17 at 10:56 am, Resident #59 stated she currently had a UTI or bladder infection, which she attributed to staff not responding to her call light and rushing through peri-care. Resident #59 stated she noticed the symptoms a few days prior as she experienced increased urinary urgency and frequency and woke up four times during the night with incontinence. Resident #59 stated that during the previous few days she experienced increased nausea and was not

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<td>F 690</td>
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<td>F 690</td>
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<td>action(s) are effective and compliance is sustained will not recur.</td>
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The DON or designee will audit medical record of five random residents and review the Bowel and Bladder evaluation, plan of care for Bowel and Bladder and Point of Care documentation related to toileting, hygiene and catheter care if applicable weekly for 4 weeks, then audit 2 resident care plans per week for 8 weeks to identify discrepancies between the care. The staff member responsible for the care plan discrepancy will be educated at the time of the finding and the care plan will be updated.

Results of the audits will be presented in the facility QAPI meeting for three months (or longer as necessary) beginning in February, with any identified negative trends addressed through education and modification of the performance plan as appropriate.

5.) Date Corrective action will be completed: February 6, 2018
F 690

Continued From page 63

feeling well enough to eat much. Resident #59 stated her pain had also increased since the development of the UTI.

On 12/13/17 at 2:28 pm, Resident #59 said some staff rushed her pericare, did not wipe thoroughly, and/or wiped in both directions. Resident #59 raised her hand and demonstrated with quick motions of her hand going up and down. The resident stated she had experienced 4 episodes of incontinence the previous night and that staff took 20 to 30 minutes to respond to each of the first two episodes, and she took herself to the bathroom without activating her call light on the third episode. Resident #59 stated the staff told her not to take herself to the bathroom, but rather wait for assistance following the third episode of incontinence. Resident #59 stated she also did not want to sit in a urine-soaked incontinent brief waiting for staff assistance as that could lead to skin breakdown. Resident #59 stated that because of cystitis and Irritable Bowel Syndrome, when "she needed to go she needed to go now." She stated staff sometimes came into her room, turned off the call light and told her they would come back to assist her to the toilet, but then would not be return and she would become incontinent and/or wait in a soiled brief until staff could assist her.

On 12/15/17 at 11:39 am, the ADON stated Resident #59's UTIs could "generally ... be related to poor peri-care" and that a lack of staffing "may have" contributed to Resident #59's UTI.

3. Resident #7 was readmitted to the facility on
**SUMMARY STATEMENT OF DEFICIENCIES**

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<td>F 690</td>
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**Continued From page 64**

9/3/17 with multiple diagnoses, including Parkinson's disease and dementia.

A Urinary Continence and Incontinence Assessment and Management policy, dated September 2010, documented the facility would provide residents with scheduled toileting, prompted toileting, and/or other interventions based upon incontinence evaluations.

The 9/10/17 admission MDS assessment documented Resident #7 was moderately cognitively impaired, frequently incontinent of bladder, incontinent of bowel, and totally dependent on 2 staff for toileting.

A bowel and bladder elimination care plan, dated 8/29/17, documented Resident #7 required the assistance of 2 staff for toilet transfers, brief changes and pericare when incontinent. The care plan did not document the frequency cares were to be provided or whether the resident was on a toileting plan.

A bowel and bladder evaluation, dated 12/5/17, documented Resident #7 was a candidate for scheduled toileting (timed voiding).

A December 2017 bladder report documented Resident #7's incontinent brief was "soaked" on 5 occasions from 12/5/17 to 12/11/17.

A Nurses Note, dated 12/9/17 at 2:05 pm, documented Resident #7 had been found on a hallway floor with "soaked through clothing."

On 12/13/17 at 3:09 pm, CNA #12 said Resident #7 was incontinent of bowel and bladder.
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<tr>
<td>F 690</td>
<td>Continued From page 65</td>
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<td>On 12/13/17 at 4:06 pm, an Interested Party said Resident #7 was incontinent of bowel and bladder and the resident's brief was to be checked and changed as needed.</td>
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<tr>
<td>F 700</td>
<td>Bedrails</td>
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<td>On 12/15/17 at 9:49 am, CNA #13 said she was not sure what Resident #7's elimination care plan had been prior to the fall on 12/9/17, but &quot;thought&quot; she changed the resident's brief before lunch that day. CNA #13 said she normally tried to change the resident's brief before- and after meals with assistance from another staff member.</td>
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<td>On 12/15/17 at 10:03 am, LPN #3 said she thought the resident's incontinence brief was to be changed every 2 hours as well as before- and after meals.</td>
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<td>On 12/14/17 at 4:08 pm and 12/15/17 at 11:34 am, the DON said Resident #7's elimination care plan had not documented when staff were to assist the resident to the toilet or when to check and change the resident's brief. She said the resident was not a candidate for a toileting program despite the bowel and bladder evaluation concluding the resident was a possible candidate for bladder retraining.</td>
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<td>§483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</td>
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### F 700

$§483.25(n)(1)$ Assess the resident for risk of entrapment from bed rails prior to installation.

$§483.25(n)(2)$ Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

$§483.25(n)(3)$ Ensure that the bed's dimensions are appropriate for the resident's size and weight.

$§483.25(n)(4)$ Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.

This REQUIREMENT is not met as evidenced by:

- Based on observation, interview, and record review and policy review, it was determined the facility failed to ensure that prior to the placement of bed rails, alternatives to bed rails were attempted, individual residents were thoroughly assessed for the risk of entrapment, and a consent was in place. This was true for 3 of 3 sample residents (#s 10, 15 and 37) and created the potential for harm from entrapment or injury related to the use of bed rails. Findings include:

  - The facility's Proper Use of Side Rails policy, revised December 2016, documented, "Side rails are only permissible if ... used to treat a resident's medical symptoms or to assist with mobility and transfer ... An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails. The risks and

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**F 700 Bed Rail(s)**

1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

Resident #10 was assessed for appropriate use of assistive devices/bed rails. The assistive devices were assessed for safety, and any concerns with these devices safety were addressed and/or corrected at the time. IDT determined these assistive devices continue to be appropriate for this resident, and updated informed consent was obtained on or before 1/15/18.

Resident #15 was assessed for appropriate use of bed rails, bed rails
## F 700

### Continued From page 67

Benefits ... will be considered for each resident. Consent for side rail use will be obtained ... after presenting potential benefits and risks ... Manufacturer instructions for ... side rails will be adhered to. The resident will be checked periodically for safety relative to side rail use. If ... usage is associated with symptoms of distress ... the resident's needs and use of side rails will be reassessed. When side rail usage is appropriate ... will assess the space between the mattress and side rails ..."

1. Resident #10 was admitted to the facility in 2009 and readmitted in 2015 with multiple diagnoses, including intervertebral disc disorder at multiple levels, encephalopathy, and anxiety disorder. On 12/4/17, the resident was also diagnosed with general muscle weakness and abnormal posture.

Resident #10's December 2017 recapitulated physician orders documented 2 half bed rails were ordered on 10/23/17.

Resident #10’s care plan documented a self care performance deficit with activities of daily living (ADL), dated 6/24/16 and revised 9/15/16. Interventions included 2 half bed rails, which were initiated 6/24/16 and revised on 3/6/17 to enable functional bed mobility.

Resident #10 was observed in bed with 2 half bed rails in the upraised position on 12/13/17 at 3:35 pm and on 12/14/17 at 10:37 am, 11:01 am and 4:00 pm.

On 12/15/17 at 11:50 am, the Director of Nursing (DON) was asked for documentation regarding...
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:**

135098

**Date Survey Completed:**

12/18/2017

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<td>F 700</td>
<td>Continued From page 68</td>
<td>side rail use for Resident #10. Later that day, the DON provided a physical restraint assessment for Resident #10, which documented 2 half side rails were ordered and applied on 10/23/17. The assessment was dated 12/13/17, 53 days after the side rails were put into use. The facility did not provide any other side rail assessments for Resident #10. The 12/13/17 assessment did not document what, if any, alternatives were attempted or did not meet the resident's needs prior to the use of side rails or whether the resident's diagnoses and medical conditions, cognition, size and weight, medications, delirium, and risk of falling were considered prior to the application of side rails.</td>
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2. Resident #15 was admitted to the facility on 6/2/17 with multiple diagnoses, including diabetes mellitus. The quarterly Minimum Data Set (MDS) assessment, dated 9/19/17, documented Resident #15 required extensive assistance of at least 2 staff for bed mobility and was dependent on at least 2 staff for transfers.

Resident 15's Care Plan, dated 11/30/17, documented the use of bilateral 1/2 side rails for bed mobility, turning, and repositioning.

On 12/12/17 at 10:37 am, Resident #15 was observed in a bariatric bed with a circular bar attached to each side of the bed frame near the head of the bed. The resident stated he could use the mobility bars if staff positioned him on his side, but the "mobility bars" were not positioned where he could use them independently.

**Provider's Plan of Correction**

**EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY**

3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.

Staff were reeducated by the DON or designee on the requirements of bed rail usage and were provided instruction on alternate interventions prior to the use of bed rails and proper measurements and maintenance of bed rails.

Prior to initiation of any bed rail, DON or ADON will be informed of the recommendation or request for bed rail use. The DON/ADON or designee will complete assessment of the resident for the use of bed rail(s). Once the assessment is completed the resident &/or interested party will be educated regarding risks of entrapment, and alternatives to bed rail(s). If the IDT determines that bed rail(s) will benefit the resident a Physician order for the bed rail(s) will be obtained, informed consent will be obtained, and plan of care updated prior to initiation of the bed rail(s).

Each resident who has bed rails will be re-assessed by the IDT quarterly or with any change in condition to determine if bed rail use continues to be appropriate.

interested party notified of the change, alert charting initiated to monitor resident during the change and appropriate staff education provided regarding the changes.
On 12/14/17 at 4:00 pm, the facility provided 2 Informed Consents, one of which was signed by Resident #15 on 12/3/16 and the other signed by the resident on 1/10/17. The Informed Consent provided risk and benefits of side rail use. A Restraint-Physical form documented on 6/6/17 that the 2 1/2 side rails had been assessed for safety and were approved for resident use.

On 12/15/17 at 11:50 am, the Director of Nursing was asked for a Resident Assessment for Resident #15’s use of bilateral side rails. The facility did not provide the requested assessment.

3. Resident #37 was admitted to the facility on 9/30/17 with diagnoses that included dementia and fracture of the right femur.

The admission MDS assessment, dated 10/7/17, documented Resident #37 was severely cognitively impaired and required extensive assistance of 2 staff for bed mobility and transfers.

Resident #37’s clinical record did not contain a Resident Assessment or care plan for the use of half side rails as of 12/13/17.

Resident #37’s clinical record documented she experienced six unwitnessed falls from bed between 10/4/17 and 12/11/17.

On 12/11/17 at 2:37 pm, Resident #37’s bed was observed with bilateral half side rails in the upraised position and body pillows at the lower portion of the bed. Resident #37 grasped her for the resident.

4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur.

The IDT will audit for the presence of bed rails in the facility. DON or designee will audit charts of 5 residents who have bed rails for appropriate orders, assessments, consents and care planning. Audits by DON or designee will be completed weekly for 4 weeks, then every other for 8 weeks. Identified concerns will be corrected at the time identified, as possible, with appropriate staff education provided as indicated.

Results of the bed rail audits will be presented in the facility QAPI meeting for 3 months (or longer as necessary) beginning in February, with any identified negative trends addressed through system modification and staff education as appropriate.

5.) Date Corrective action will be completed:  February 8, 2018
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right side rail and unsuccessfully attempted to reposition herself higher on the bed. The resident then attempted to swing her legs out of bed and called out, "Help, help, help." CNA #11 entered the room and began lowering Resident #37's bed and placing a draw sheet under the resident. Resident #37 attempted to swing her legs off the bed again, and stated her back hurt and that she needed to get up. CNA #8 entered the room and the two CNAs used the draw sheet to reposition Resident #37 in bed. Resident #37 stated she felt better after the repositioning.

A 12/13/17 Risk verses Benefits Assessment documenting Resident #37 used bilateral half side rails was not signed by Resident #37's responsible party.

A 12/13/17 Nursing Physical Restraint Assessment documented Resident #37 utilized bilateral half side rails. The assessment documented the physician ordered the side rails on 12/13/17, the resident's family was notified and agreed to use of the side rails on 12/14/17, and the side rails were applied to the resident's bed on 12/14/17 at 12:00 am.

On 12/15/17 at 10:54 am, the Assistant Director of Nursing (ADON) stated it "appears" the completion of Resident #37's side rail assessment "was overlooked." The ADON stated she had just completed a risk verses benefit and was waiting for the consent to be signed by Resident #37's responsible party. The ADON stated the facility's practice was to complete the assessments prior to placing the side rails, and that the facility would re-evaluate the need for side rails should a resident experience a change.
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<td>F 700</td>
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<td>Continued From page 71 in condition that required a re-evaluation. The ADON stated the facility also completed quarterly side rail assessments.</td>
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<tr>
<td>F 725</td>
<td>SS=E</td>
<td>Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)</td>
<td>F 725</td>
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<td>§483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility’s resident population in accordance with the facility assessment required at §483.70(e).</td>
<td>2/6/18</td>
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§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not
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<td>F 725</td>
<td>Continued From page 72 limited to nurse aides.</td>
<td>F 725</td>
<td>F 725 Sufficient Nursing Staff</td>
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<td>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility grievances, it was determined the facility failed to ensure there was sufficient staffing at all times to provide for the needs, safety, and psychosocial well-being of all residents. This was true for 4 sampled residents (#59, 68, 54, and 33) and 5 of 8 residents in a group interview, and had the potential to affect all other residents in the facility. This deficient practice created the potential for psychosocial and physical harm if call lights were not answered in a timely manner, and/or residents experienced a delay or did not receive care. Findings include: 1. Resident #59 was admitted to the facility on 10/25/17 with diagnoses that included chronic kidney disease, history of urinary tract infections (UTIs), chronic cystitis, and irritable bowel syndrome (IBS). An initial Minimum Data Set (MDS) assessment, dated 11/1/17, documented Resident #59 was cognitively intact, was frequently incontinent, and required extensive assistance of one staff member for toileting. The MDS documented Resident #59 required physical assistance of one staff member with bathing. a. Resident #59's Bowel and Bladder Elimination Care Plan, initiated 10/25/17, documented she</td>
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<td>1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident 59 no longer resides in the facility, unable to provide corrective action for the deficient practice. Resident 68, 54, 33 unable to go back and complete missed showers. Conducting audit to ensure residents receive their showers as per their preference. 2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken; Residents were evaluated for showers, call light duration was audited by the IDT and identified concerns were corrected at the time identified with appropriate staff education provided as indicated. 3.) What measures will be put in place or what systemic change you will make to</td>
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<td>F 725</td>
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<td>ensure that the deficient practice does not recur.</td>
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<td>required extensive assistance from two staff members with toilet transfers, incontinence product change, and peri-care. The care plan documented staff were to provide peri-care after each incontinent episode. The care plan documented she had a toileting schedule, and to provide as needed assistance as well.</td>
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<td>Should there be a call in that results in no designated bath aide, nursing staff have been given an alternate shower schedule that divides the daily designated showers between all CNA’s on day and evening shift.</td>
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<td>A Grievance Report, dated 10/31/17, documented Resident #59 activated her call light when she needed to go to the restroom and staff did not respond for 20-30 minutes. The report documented Resident #59 sometimes could not hold her bladder anymore and she experienced incontinence episodes. The report documented Resident #59 had a urinary rash and should not be left in soiled incontinence products.</td>
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<td>Recruitment efforts were evaluated for nursing staff: a</td>
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<td>On 12/12/17 at 9:30 am, Resident #59 activated her call light and Certified Nursing Assistant (CNA) #5 entered the room. Resident #59 stated she had to go to the bathroom. CNA #5 stated she would assist Resident #59 shortly, turned the call light off, and left the room.</td>
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<td>• additional advertising with sign on bonus of $1500 dollars was implemented for both LN and CNA staff to include multiple advertisements on Craigslist, Indeed.com, etc.</td>
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<td>On 12/12/17 at 9:55 am, Resident #59 stated she had activated her call light earlier and a staff member had entered her room, turned off the call light, and told her she would be right back. Resident #59 stated she waited for several minutes, but could not hold her bowels anymore and had &quot;an accident.&quot;</td>
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<td>• Staff incentive to refer a LN or CNA to work at VVNR was increased to $750.</td>
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<td>On 12/13/17 at 2:28 pm, Resident #59 stated she developed a bladder infection just recently. Resident #59 attributed the bladder infection to staff not responding to her call light and staff rushing through peri-care. Resident #59 stated</td>
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<td>• Wages of CNA staff evaluated and CNA’s identified to have wage suppression have received an increase in their hourly wage.</td>
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<td>• Incentive bonuses are offered to nursing staff to fill in vacant shifts that range from $50-150 per shift.</td>
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<td>• Attendance issues, staff who violate facility attendance policy receive counseling from DNS per facility policy.</td>
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<td>• Monthly and weekend incentive raffles for employees that do not call in implemented in November and continue, include significant monetary prizes.</td>
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<td>• Avalon recruitment regularly updated to vacant nursing positions for assist with recruitment.</td>
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<td>• Applications received from nursing applicants receive prompt follow up to set</td>
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### Summary of Deficiencies

- **F 725**: Required extensive assistance from two staff members with toilet transfers, incontinence product change, and peri-care. The care plan documented staff were to provide peri-care after each incontinent episode. The care plan documented she had a toileting schedule, and to provide as needed assistance as well.

- **A Grievance Report, dated 10/31/17**: Documented Resident #59 activated her call light when she needed to go to the restroom and staff did not respond for 20-30 minutes. The report documented Resident #59 sometimes could not hold her bladder anymore and she experienced incontinence episodes. The report documented Resident #59 had a urinary rash and should not be left in soiled incontinence products.

- **On 12/12/17 at 9:30 am**: Resident #59 activated her call light and Certified Nursing Assistant (CNA) #5 entered the room. Resident #59 stated she had to go to the bathroom. CNA #5 stated she would assist Resident #59 shortly, turned the call light off, and left the room.

- **On 12/12/17 at 9:55 am**: Resident #59 stated she had activated her call light earlier and a staff member had entered her room, turned off the call light, and told her she would be right back. Resident #59 stated she waited for several minutes, but could not hold her bowels anymore and had "an accident."

- **On 12/13/17 at 2:28 pm**: Resident #59 stated she developed a bladder infection just recently. Resident #59 attributed the bladder infection to staff not responding to her call light and staff rushing through peri-care. Resident #59 stated...
### SUMMARY STATEMENT OF DEFICIENCIES

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<td>F 725</td>
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<td>F 725</td>
<td>up interview, hire as appropriate and onboarding is in place to hire the staff and assist them to start working.</td>
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<td>• Facility has implemented CREW app to communicate with all staff, especially nursing staff to cover vacant positions.</td>
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<td>• Personnel from other departments are offered extra shifts to assist on the floor with tasks that are not required to be completed by a CNA or a licensed nurse such as passing linen, restocking, answer call lights and assist with non-clinical needs, pass trays in the dining room, bed making, etc.</td>
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<td>Grievance Reports, dated 11/10/17 and 11/13/17, documented Resident #59 was not receiving two showers a week. The report documented when the facility was short staffed they reassigned the shower aides to cover the shortages in general resident care.</td>
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<td>DNS and nurse managers to review the daily tasks for CNA staffing to include hygiene care, assist with ADL’s and transfers, showers, call light response. Organization of tasks will be completed to ensure productivity and appropriate priority to tasks are outlined.</td>
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<td>Nursing staff were reeducated by the DON or designee on the daily tasks to assure productivity and priorities to include showers, answering call lights timely, assisting residents out of the bed, toileting.</td>
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<td>4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur.</td>
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<td>DON or designee, ED, SDC and Staffing Coordinator will meet weekly until a lesser</td>
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#### F 725 Continued From page 74

She experienced four incontinence episodes the previous night and the first two times, staff took 20-30 minutes to respond. Resident #59 stated the third time it happened she took herself to the bathroom and did not use her call light.

b. Resident #59's Activities of Daily Living (ADL) Care Plan, revised 10/25/17, documented she required minimal assistance of 1 staff member with bathing and showers.

Resident #59’s 10/25/17 through 12/14/17 ADL Shower Documentation Survey Report documented she was scheduled to receive showers on Wednesdays and Sundays. The flowsheet documented Resident #59 did not receive a shower on 11/3/17, 11/10/17, 11/17/17, 11/20/17, 11/24/17, 11/27/17, 12/1/17, and 12/10/17. According to the flowsheet, the longest length of time Resident #59 went without a shower was 11 days, between 11/15/17 and 11/26/17.

Grievance Reports, dated 11/10/17 and 11/13/17, documented Resident #59 was not receiving two showers a week. The report documented when the facility was short staffed they reassigned the shower aides to cover the shortages in general resident care.

On 12/13/17 at 2:28 pm, Resident #59 stated she was frustrated that the facility was not providing her with at least two showers a week. Resident #59 stated she was used to showering more than twice weekly and she did not receive one shower a week on some occasions.

On 12/18/17 at 8:17 am, Resident #59's
F 725 Continued From page 75

Interested Party stated he/she frequently visited the resident. The Interested Party stated he/she had witnessed Resident #59 activate her call light and staff did not respond in time to take her to the bathroom. The Interested Party stated he/she had timed the CNAs response times and they varied from 5 minutes to 30 minutes. The Interested Party stated Resident #59 had called him/her multiple times upset about occurrences of incontinence due to staff not responding to the resident's call light, and lack of showers. The Interested Party stated the facility had not provided Resident #59 with even two showers a week as promised. The Interested Party stated he/she had filed grievances related to these issues and the facility had not resolved the issues. The Interested Party stated the facility told him/her that they were short staff and were working on adding more staff. The Interested Party stated the residents should not have to suffer because the facility was short staffed.

2. On 12/12/17 at 3:00 pm, during a resident group interview, 5 of 8 residents said call lights were not answered in a timely manner and they sometimes had to wait up to an hour for staff to respond. A resident in the group interview stated staff often turned off an activated call light with the assurance they would come back, but then did not return. Several residents said they knew when local university football games were on television because staff watched the games rather than answer call lights in a timely manner. Several of the residents said the facility was generally short 2 CNAs on the floor, and 6 of the 8 residents in attendance stated showers were not consistently provided because shower aides were reassigned to general CNA duties when the frequency is determined, to review staffing and assure advertising, interviews and hiring is completed to ensure compliance is sustained.

Beginning the week of 1/15/18 IDT will complete rounds to audit response to call light, timely toileting and observe and/or interview to identify any resident care concerns to ensure compliance. Rounds will be completed 3 times weekly for 4 weeks, then 2 times weekly for 8 weeks. Identified concerns will be corrected at the time identified, as possible, with appropriate staff education provided as indicated.

The DON or designee will complete a bathing documentation audit to ensure bathing is completed per care plan. Audit will be completed 3 times weekly for 4 weeks, then 2 times weekly for 8 weeks. Identified concerns will be corrected at the time identified, as possible & referred to DON for resolution.

Results of rounds and weekly staffing reviews will be presented in the facility QAPI meeting for three months (or longer as necessary) beginning in February, with any identified negative trends addressed through system modification and staff education as appropriate.

5.) Date Corrective action will be completed: February 6, 2018
### Summary Statement of Deficiencies

**F 725 Continued From page 76**

- **facility was short staffed.**

  3. On 12/12/17 at 8:23 am, Resident #68 stated the facility did not have sufficient staff to complete showers. Resident #68 stated she was scheduled for showers on Sundays and Wednesdays, which the facility did not consistently provide. Resident #68 stated call light response times varied depending on how many "staff showed up," and that on at least 5 occasions it had taken staff up to 30 minutes to respond to her call light.

  4. On 12/12/17 at 11:13 am, Resident #54 stated there was not enough staff to provide showers, especially on weekends. Resident #54 stated staff often took up to 30 minutes to respond to her call light.

  5. On 12/12/17 at 11:56 am, Resident #33 stated there was not enough staff to provide showers.

  6. On 12/12/17 at 11:34 am, a resident who did not want to be identified, said she had to wait more than an hour that morning for staff to answer her call light.

  7. **Staff Interviews**

     * On 12/12/17 at 1:03 pm, Registered Nurse (RN) #2 stated residents had voiced their concerns of not receiving showers, which she said she had passed along to upper management. RN #2 stated shower aides were often reassigned when other staff called in sick. RN #2 stated residents had also spoken to her about long staff response times to call lights. RN #2 stated staffing levels did not always meet the acuity level of residents.
**SUMMARY STATEMENT OF DEFICIENCIES**

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Continued From page 77

* On 12/13/17 at 3:09 pm, CNA #12 said the facility was short staffed at least 2 days a week and on various shifts.

* On 12/15/17 at 11:30 am, the Director of Nursing (DON) said she was aware the facility often lacked a sufficient number of staff and that first restorative aides and then the shower aides were reassigned to cover for staffing shortages. She said the Quality Assurance Committee had attempted to address the staffing issue by offering extra pay to staff who come in on their days off.

* On 12/15/17 at 11:39 am, the Assistant Director of Nursing (ADON) stated staff responding to call lights had been instructed not to turn the call off until the resident's needs had been met. The ADON stated the facility's call light response times were directly related to staffing levels and that she was aware residents did not receive adequate bathing because of insufficient staffing as well.

* On 12/15/17 at 5:24 pm, the Executive Director said he was aware of the lack of staff and had been trying several solutions, including staff incentives and use of outside agency staff.

Please refer to F677 as it relates to the facility's failure to ensure residents were provided assistance with bathing or oral care consistent with their needs.

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**F 744**

Treatment/Service for Dementia

CFR(s): 483.40(b)(3)

§483.40(b)(3) A resident who displays or is
F 744 Continued From page 78

F 744

F744 Treatment/Service for Dementia
1.) What corrective action(s) will be
accomplished for those residents found to
have been affected by the deficient
practice.

Resident #37 Impaired Cognition Care Plan was revised and updated to reflect resident’s cognitive deficits.

Behavioral care plan for resident #37 was initiated which identifies behaviors related to Dementia and provides interventions for staff to respond to behaviors.

2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

All residents plan of care related to impaired cognition were audited and revised as appropriate to reflect cognition and behaviors related to cognition and appropriate interventions to be used by staff by LSW on or before 2/6/18.

Identified concerns were corrected at the time identified with appropriate staff education provided as indicated.

3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.

Social services staff will audit care plans to update behaviors and interventions as needed with a cognitive/behavior meeting.

F 744

diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, it was determined the facility failed to ensure residents received care and services necessary to achieve their highest practicable physical, emotional, and psychosocial well being. This was true for 1 of 4 residents (#37) sampled for dementia care and resulted in psychosocial harm when staff took the resident into the bathroom against her wishes and did not stop a shower after the resident repeatedly stated, “Ow,” “Stop,” and “Oh God help me.” Findings include:

Resident #37 was admitted to the facility on 9/30/17 with diagnoses that included dementia with behavioral disturbances.

The admission Minimum Data Set (MDS) assessment, dated 10/7/17, documented Resident #27 experienced severe cognitive impairment, required extensive assistance of 2 staff for bed mobility, transfers, and toileting, and the assistance of 1 staff with bathing.

Resident #37’s Impaired Cognition Care Plan, revised 10/11/17, documented staff were to ask "yes/no" questions to determine needs, reduce distractions and speak in simple direct sentences when communicating with the resident, provide cues, and cease communication efforts if the resident became agitated. The care plan did not document Resident #37’s specific behaviors nor
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| F 744     |     | Continued From page 79 direct staff on how to respond to the resident when behaviors were present. | F 744     |     | bi-weekly as needed. Social service staff will meet with IDT to determine the best approach to assist residents whose needs may have changed by expanding psychotropic meeting to include a more comprehensive update of behaviors and interventions. Facility staff were educated on the management of residents with Dementia by the SDC or designee. Upon hire and annually facility staff will receive facility provided dementia training to ensure understanding.  
4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur. Social services staff will audit care plans to update behaviors and interventions as needed with a cognitive/behavior meeting bi-weekly as needed. Social Services or their designee will complete rounds on 5 residents weekly x 4 weeks then 2 residents weekly x 8 weeks to ensure that that care staff is implementing and delivering the care to residents as per the resident’s plan of care. Results of the audits will be presented in the facility QAPI meeting for three months (or longer as necessary) beginning in February, with any identified negative trends addressed through education and modification of the performance plan as appropriate.  
5.) Date Corrective action will be completed: February 6, 2018 |
A. BUILDING
______________________
135098

B. WING
______________________

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY
COMPLETED

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

PRINTED: 07/09/2018

FORM APPROVED

VALLEY VIEW NURSING & REHABILITATION

1140 NORTH ALLUMBAUGH STREET
BOISE, ID 83704

(X4) ID
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID
PREFIX
TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCE TO THE APPROPRIATE
DEFICIENCY)

(X5)
COMPLETION
DATE

F 744 Continued From page 80

"F***ing leave me alone! Help, help, help me!"
Resident #37 reached out and clutched the
bathroom doorjamb with her arms to prevent staff
from pushing her through the threshold and
planted her feet firmly to prevent entry into the
bathroom. RN #2 grasped the resident's hand
from the doorjamb and asked Resident #37 to
"hold" her hand. Resident #37 released her grasp
on the doorjamb and raised her feet as CNA #8
rolled Resident #37 in the wheelchair through
the bathroom door. Resident #37 then bit RN #2's
hand. Throughout this observation, Resident #37
continued yelling, "No, no, help, me, help
me! F***ing leave me alone!" RN #2 left the room
when CNA #14 entered to provide assistance.
CNA #8 asked Resident #37 to stand up and
grasp a support bar on the bathroom wall near
the toilet. Resident #37 continued to sit in her
wheelchair and yelled "Help, help, help me.
F***ing leave me alone!" As CNA #14 attempted
to place a gait belt around Resident #37's waist,
Resident #37 turned and slapped CNA #14 in the
face. The two CNAs asked Resident #37 to stand
up and grasp the bar on the wall three more
times while trying to lift her out of the chair.
Resident #37 continued to refuse and called out,
"Help, help, help, help! F***ing leave me alone!"
The CNAs stopped their attempts to stand
Resident #37, transported her from the
bathroom, and wheeled her back to the TV room.
The CNAs stated they would attempt to toilet the
resident later. Resident #37's roommate stated
Resident #37 cried out often in a similar fashion
when staff attempted to provide cares. The
resident's roommate stated staff normally
continued with what they were doing and
Resident #37 typically stopped yelling and
fighting once staff finished with cares.
On 12/13/17 at 9:53 am, Resident #37 was observed in her wheelchair watching television in the TV room. At 9:58 am, CNA #5 approached and asked Resident #37 if she wanted to go to bed. Resident #37 stated she was tired but wanted to stay where she was. CNA #5 asked Resident #37 if she wanted a snack and Resident #37 stated, "No." At 10:28 am, Resident #37 declined the DON's offer of fluids. At 11:23 am, a liquid was observed under Resident #37's wheelchair as multiple staff over the next 6 minutes approached the resident with offers to take her to the toilet. Resident #37 responded to each staff by stated either, "No," or Leave me alone." The volume of Resident #37's voice steadily increased with each staff offer until Resident #37 yelled, "Everyone leave me alone!"

At 11:29 am, CNA #5 approached Resident #37, squatted down to the resident's eye level, and stated, "I want to take you for a walk. I have something to show you and I want your opinion on it." Resident #37 said she did not want to go for walk and told CNA #5 to "leave her alone." CNA #5 continued to ask Resident #37 if the CNA could show her something in her room and Resident #37 continued to state, "Leave me alone." CNA #5 stood up and walked around to the back side of Resident #37's wheelchair and attempted to move her towards her room.

Resident #37 yelled loudly, "Leave me alone! No, no, no, no!" CNA #5 stopped, put her hands up, and left the TV room. At 11:36 am, CNA #4 approached Resident #37 in the TV room, said, "Hi," and then wheeled Resident #37 towards her room. Resident #37 was quiet until she came into view of the bathroom and then started crying out, "No! Help me, help me, help!"
F 744 Continued From page 82

At 11:37 am, as CNA #4 continued wheeling Resident #37 towards the bathroom, Resident #37 continued crying out, "Help me, help me. Whoever is out there help me." Resident #37's roommate was present as CNA #4 brought her into their room. The bathroom door was open, the window blinds were open, and the curtains were drawn back leaving an unobstructed view of Resident #37 while she was taken into the bathroom. CNA #4 continued pushing Resident #37 into the bathroom as the resident continued to resist being taken into the bathroom. People outside could be seen walking past Resident #37's window as CNA #4 began disrobing the resident. Resident #37's roommate drew the window curtain closed as Resident #37 cried out, "Help me! Oh dear God, help me, help, help, help me." As the roommate wheeled herself out of the room, she stated, "It's okay [Resident #37's name], you are okay." CNA #4 continued with her task while Resident #37 continued in a loud voice, "Help me. Oh dear God, help me, help, help, help me." At 11:40 am, CNA #4 stated to Resident #37 she had finished and wheeled Resident #37 out of the bathroom. Resident #37 dabbed her teary eyes with a tissue and was sniffing. CNA #4 then wheeled Resident #37 past the open bathroom door blocking Resident #37's path to the room door and wheeled the resident to the dining room for lunch.

On 12/13/17 at 2:20 pm, Licensed Practical Nurse (LPN) #1 approached Resident #37 in the TV room and stated, "It's time for your Tylenol." Resident #37 responded, "Okay," and took the medication.
F 744 Continued From page 83

On 12/13/17 at 2:35 pm, the DON approached Resident #37 in the TV room and asked her if she needed to use the bathroom. Resident #37 responded, "No," and thanked the DON for asking. At 2:45 pm, CNA #10 approached Resident #37 and said, "We need to try and go to the bathroom. You haven't been for a while." Resident #37 responded, "Okay." Resident #37 went to the bathroom quietly and stated, "Help, help" occasionally throughout the process. CNA #9 assisted CNA #10 clean Resident #37's urine-soaked wheelchair pad before exiting the room for more cleaning towels. As CNA #10 advised the resident they had to wait for additional cleaning towels, Resident #37 asked her "hurry up" and "help" her.

On 12/13/17 at 3:00 pm, CNA #10 stated she normally worked in another area of the facility and that her interaction with Resident #37 was her first experience with the resident. CNA #10 stated residents with dementia sometimes required a different approach from that used with residents without dementia. CNA #10 stated she did not know what instructions Resident #37's care plan or the CNA Kardex provided to staff when Resident #37 refused toileting.

On 12/13/17 at 3:27 pm, LPN #1 stated she normally worked in another area of the facility and was not familiar with Resident #37's normal routine. LPN #1 stated Resident #37 refused her medications that morning, but then accepted the medications when approached in a different manner that afternoon. LPN #1 stated she was aware Resident #37 refused toileting and would remain in soiled adult briefs "all day if she could." LPN #1 stated she was not aware what approach
Continued From page 84

worked best with the resident when she refused toileting, how to approach Resident #37 when she refused toileting, or what the resident's care plan directed staff to do when toileting was refused. LPN #1 then reviewed Resident #37's care plan and stated it did not specify what interventions staff were to take when Resident #37 refused toileting.

On 12/13/17 at 3:50 pm, CNA #9 stated she sought assistance from other staff, including the DON and nurses, when Resident #37 refused cares, including toileting. CNA #9 stated she did not know what instructions the CNA Kardex provided if Resident #37 refused toileting, became combative, or insisted staff stop providing cares. CNA #9 reviewed the Kardex and stated it did not include such direction.

On 12/14/17 at 9:03 am, CNA #4 stated she did not have much experience working with Resident #37, did not receive specific instruction for how to assist Resident #37 with cares, and was not familiar with the resident's care plan or CNA Kardex. CNA #4 stated other staff told her Resident #37 often refused toileting, so when the Licensed Social Worker (LSW) asked her to toilet Resident #37 the day before she decided to "just take her" into the bathroom "instead of asking" first for the resident's permission. CNA #4 stated Resident #37 was "fine" until she got closer to the bathroom, at which time the resident began refusing the effort and attempted to stop CNA #4 from toileting her. CNA #4 stated she would normally close the curtains or otherwise ensure resident privacy, but became distracted with Resident #37's reaction to toileting. CNA #4 stated she was not provided care instruction for

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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:** 135098

**MULTIPLE CONSTRUCTION**

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**SUMMARY STATEMENT OF DEFICIENCIES**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**OMB NO. 0938-0391**

| (X3) DATE SURVEY COMPLETED | 12/18/2017 |

**NAME OF PROVIDER OR SUPPLIER**

**NAME OF PROVIDER OR SUPPLIER**

**VALLEY VIEW NURSING & REHABILITATION**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

**1140 NORTH ALLUMBAUGH STREET**

**BOISE, ID 83704**

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**SUMMARY STATEMENT OF DEFICIENCIES**

**EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION**

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**F 744 Continued From page 85**

those instances when Resident #37 refused cares or asked staff to stop cares already underway.

On 12/14/17 at 9:10 am, Resident #37 was observed in a wheelchair near the nurses station. After initially declining an offer to shower, the DON and LSW #1 reminded the resident she had a hair appointment that day and Resident #37 consented to a shower.

On 12/14/17 at 9:19 am, CNA #2 wheeled Resident #37 into the shower room. At 9:21 am, Resident #37 stated, "Help me, help me, help me. Help, help, help, help. Oh dear God, oh dear God." At 9:26 am Resident #37's vocal volume increased as she continued saying, "Help, help, help me." At 9:28 am, Resident #37's voice level continued to rise as she stated, "Ow, that hurts. Ow that hurts. Ow, ow, help me, help me, help help, help! Oh God, no!" CNA #2 stated, "[Resident #37's name] you are okay, I will be done soon." CNA #2 completed the shower at 9:34 am and brought Resident #37 out of the shower room.

On 12/14/17 at 5:46 pm, LSW #1 stated Resident #37 slept about 4 hours a night, could converse with staff for a few minutes before becoming distracted, had no long-term memory impairment, and experienced some short-term difficulty. LSW #1 stated Resident #37 was difficult to redirect and changed her mind easily, staff were instructed to redirect Resident #37 when she refused cares, and staff were to offer Resident #37 hot cocoa when efforts to redirect were unsuccessful. The LSW stated hot cocoa was also used as a "reward" with Resident #37 when
### Statement of Deficiencies and Plan of Correction

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<td>cares were completed. LSW #1 stated staff should not take Resident #37 into a room she refused to enter, not leave the resident in soiled adult briefs for extended periods of time, and attempt a different approach when the resident refused toileting. LSW #1 stated Resident #37 appeared to &quot;have an issue&quot; with her bathroom and the facility would look for another way to accommodate those needs. LSW #1 stated Resident #37 seemed to respond better to staff directing her care rather than asking her yes/no questions related to care. LSW #1 stated staff should immediately cease showering the resident if she expressed discomfort or distress, and that the current care plan should provide clear descriptions and direction to staff for addressing Resident #37's behaviors and/or refusal of cares.</td>
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**Summary Statement of Deficiencies**

Each deficiency must be preceded by full regulatory or LSC identifying information.
### Summary Statement of Deficiencies

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| F 758     | SS=D CFR(s): 483.45(c)(3)(e)(1)-(5) | §483.45(e) Psychotropic Drugs.  
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:  
(i) Anti-psychotic;  
(ii) Anti-depressant;  
(iii) Anti-anxiety; and  
(iv) Hypnotic  
Based on a comprehensive assessment of a resident, the facility must ensure that---  
§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;  
§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;  
§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and  
§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is
F 758 Continued From page 88

appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:

Based on interview and record review, it was determined the facility failed to ensure there was a clear indication for psychotropic medications and that non-pharmacological approaches were attempted prior to the use of these medications, unless contraindicated. This was true for 1 of 2 sample residents (#89) reviewed for unnecessary medications and created the potential for residents to experience adverse reactions from unnecessary anti-anxiety medications. Findings include:

Resident #89 was admitted to the facility on 11/3/17 with multiple diagnoses, including vascular dementia with behavioral disturbance and frontal lobe and executive function deficit. The resident began hospice care on 12/5/17.

Resident #89's care plan documented an actual alteration in mood and behavior on 11/3/17 and included interventions for the administration of psychotropic medications as ordered.

A hospice physician order, dated 12/5/17, directed staff to administer Lorazepam 0.25 milliliters (ml), 0.5 milligrams (mg), every 4 hours.

F 758 Free from Unnec Psychotropic Meds/PRN Use

1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

Resident #89 no longer resides in the facility, unable to correct deficient practice

2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

Facility residents with an order for PRN psychotropic were audited by DON or designee to ensure that the resident had a monitor for behaviors and a monitor for non-pharmacological interventions and a care plan consistent with the behaviors and interventions. The DON or IDT will provide educate to the resident’s physician on the regulation limiting PRN psychotropic orders to 14 days. The resident’s with PRN psychotropic medication will have their MD document...
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<td>758</td>
<td>Continued From page 89</td>
<td>as needed (PRN) for anxiety and restlessness.</td>
<td>758</td>
<td>the rationale for the continued prn psychotropic medication use.</td>
<td>3)</td>
<td>What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.</td>
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<td></td>
<td>Resident #89's December 2017 Medication Administration Record (MAR) documented Lorazepam 0.5 mg was administered once a day from 12/6/17 through 12/9/17 with positive effects each time.</td>
<td></td>
<td>Nursing staff were reeducated by the DON or designee on the expectations regarding non-pharmacological interventions, documentation of behaviors, interventions and how to identify issues/concerns related to this requirement.</td>
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<td></td>
<td>A 12/6/17 at 8:01 pm Progress Note documented Lorazepam was administered for &quot;anxiety/restlessness s/s (signs and symptoms) restlessness,&quot; but did not describe how the resident was anxious or restless.</td>
<td></td>
<td>4) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained.</td>
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<td>A 12/7/17 at 1:08 pm Progress Note documented Lorazepam was administered when the resident was &quot;restless and agitated, noted by legs shaking and arms waving about.&quot;</td>
<td></td>
<td>The DON or designee will complete audits to identify residents who have an order for a PRN psychotropic medication to ensure it does not exceed 14 day use without the proper physician documentation. The audit will ensure that the behaviors and non-pharmacological interventions are documented properly prior to the administration of the PRN psychotropic medication. Audits will be completed randomly 3 times weekly for 4 weeks, then 2 times weekly for 8 weeks. Identified concerns will be corrected at the time identified, as possible, with appropriate staff education provided as indicated.</td>
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<td>A 12/8/17 at 9:28 am Progress Note documented Lorazepam was administered when the resident was &quot;agitated, moving his legs about and trying to grab onto things.&quot;</td>
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<td>A 12/9/17 at 11:43 am Progress Note documented Lorazepam was administered for &quot;anxiety/restlessness&quot; without further explanation.</td>
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<td>Resident #89's December 2017 Monitors records documented physically aggressive behavior toward staff and swearing at staff were the only 2 behaviors being monitored. No behaviors were documented between 12/6/17 and 12/9/17.</td>
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<td>On 12/14/17 at 12:33 pm, Social Worker #1 said she was not familiar with the behavior monitor documentation by nurses.</td>
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**Valley View Nursing & Rehabilitation**

1140 North Allumbaugh Street
Boise, ID 83704

**Summary Statement of Deficiencies**

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
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<tbody>
<tr>
<td>F 758</td>
<td>Continued From page 90</td>
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On 12/15/17 at 12:47 pm, the Director of Nursing (DON) reviewed Resident #89's December Monitors, MAR, and Progress Notes. The DON said no behaviors were documented and there was no evidence that non-pharmacological interventions were attempted prior to the administration of Lorazepam.

**Food Procurement, Store/Prepare/Serve-Sanitary**

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<tr>
<th>ID</th>
<th>Prefix</th>
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<th>Completion Date</th>
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<tbody>
<tr>
<td>F 812</td>
<td>SS=E</td>
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<td>2/6/18</td>
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§483.60(i) Food safety requirements. The facility must -

- §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
- §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

This REQUIREMENT is not met as evidenced by:

- Based on observation and staff interview, it was determined the facility failed to ensure food was prepared and served under sanitary conditions.

Results of rounds will be presented in the facility QAPI meeting for three months (or longer as necessary) beginning in February, with any identified negative trends addressed through system modification and staff education as appropriate.

5) Date Corrective action will be completed: February 6, 2018
### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID/PREFIX/TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 812</td>
<td>Continued From page 91 when staff were observed in the kitchen without hair restrains. This affected 19 of 20 sampled residents (#s 7, 8, 10, 11, 15, 19, 27, 31, 37, 48, 51, 59, 61, 68, 75, 83, 89, 90 and 91) and had the potential to affect all residents who dined in the facility. This failure created the potential for contamination of food and exposed residents to potential disease causing pathogens. Findings include:</td>
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<td>The 2013 FDA Food Code, Chapter 2, Part 2-4, Hygiene Practices, Hair Restraints, subpart 402.11, Effectiveness, documented, &quot;(A) Except as provided ... food employees shall wear hair restrants such as hats, hair coverings or nets, beard restrants, and clothing that covers body hair, that ... effectively keep their hair from contacting exposed food...&quot;</td>
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<td>On 12/13/17 at 1:16 pm, Kitchen Staff (KS) #1 was observed clearing tables in the first-floor dining room. KS #1 was observed entering the first-floor warming kitchen without a hair restraint. When asked whether a hair net was required in the warming kitchen, KS #1 shrugged her shoulders and nodded &quot;yes.&quot;</td>
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<td>On 12/13/17 at 1:25 pm, the Certified Dietary Manager (CDM) stated any staff entering the warming kitchen was required to wear a hair restraint.</td>
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<td>On 12/14/17 at 12:17 pm, KS #1 was observed entering the first-floor warming kitchen without a hair restraint. The CDM stated, &quot;Where is your hair net? You know you are to have one on.&quot;</td>
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<td>F 812 accomplished for those residents found to have been affected by the deficient practice. Dietary staff were re-educated on the requirement to wear a hairnet when in warming kitchen. 2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken; Residents served out of the warming kitchen have the potential to be affected. 3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. Department managers, during their dining duty, will monitor for the use of hairnets. They will correct noncompliance if found to occur. Ongoing training to all departments regarding the use of hairnets. 4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur. Department managers will report compliance weekly at stand up. Results of weekly reports will be presented in monthly QAPI meeting. Any negative trends identified will be addressed and staff education as appropriate.</td>
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F 812 Continued From page 92

F 880 Infection Prevention & Control
SS=E CFR(s): 483.80(a)(1)(2)(4)(e)(f)

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of
### SUMMARY STATEMENT OF DEFICIENCIES

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<th>ID PREFIX TAG</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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Continued From page 93

Communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.

Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.

The facility will conduct an annual review of its IPCP and update their program, as necessary.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and policy review, it was determined the facility failed to ensure infection control measures were
consistently implemented. This was true for 7 residents (#5, #15, #18, #31, #40, #51, #59, #78, and #86) when staff failed to perform effective hand hygiene during resident cares. Additionally, it was determined the facility failed to practice universal precautions when catheter tubing was observed on the floor in a common area (Resident #86); when staff failed to utilize a barrier for a multi-resident use glucometer in a resident room and on a medication cart (Resident #40); and for 9 random residents observed during a meal service in the dining room. In addition, the facility policy on hand hygiene practice was inconsistent with current Center for Disease Control (CDC) guidelines. These failures created the potential for the spread of infection among residents. Findings include:

1. The CDC recommended the following procedure for hand hygiene with soap and water:

   * Wet hands first with water,
   * Apply the recommended amount of anti-bacterial soap,
   * Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers,
   * Rinse hands with water and use disposable towels to dry, and
   * Use towel to turn off the faucet.

   The CDC guidelines also documented other entities had recommended cleaning hands with soap and water for approximately 20 seconds and documented either amount of time was acceptable.

   The CDC recommended the following procedure:

   1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

   Nursing and Dietary staff were educated regarding infection control practices related to handwashing, during resident cares and meal service, and assisting residents with food intake.

   LPN #1 received 1:1 education with DNS and SDC related to the proper facility procedure for obtaining resident blood glucose and management of the glucometer.

   Resident #89 has discharged from the facility, unable to correct deficient practice.

   2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

   Facility employees received education regarding Foley catheter care management from the SDC or designee.

   Rounds conducted for residents who have a Foley catheter in place completed.
### Summary Statement of Deficiencies

#### F 880

**Continued From page 95**

For alcohol-based hand sanitizer:

- Apply product on hands and rub hands together,
- Cover all surfaces until hands feel dry, which should take approximately 20 seconds.

The facility's Infection Control Guidelines for All Nursing Procedures policy, dated August 2012, documented staff "must" wash their hands for 10 - 15 seconds when using soap and water. The procedure did not include documentation for how long staff were to rub their hands together using alcohol-based hand sanitizer.

#### 2. Hand Hygiene Observations and Interviews

On 12/11/17 at 4:23 pm, CNA #8 and CNA #11 were observed assisting Resident #18 out of bed with a mechanical Hoyer lift. The CNAs placed an oxygen delivery device onto the resident's face and brushed her hair. Resident #18 was observed coughing occasionally through the observation. The CNAs placed foot pedals onto a wheelchair, left the resident in the wheelchair, and entered the next resident room with the Hoyer lift. Neither CNA performed hand hygiene while in Resident #18's room.

On 12/11/17 at 4:28 pm, CNA #8 and CNA #11 were observed leaving Resident #18's room and entering Resident #5's room with a Hoyer lift. The CNAs assisted Resident #5 out of bed and into a wheelchair without performing hand hygiene from the previous resident (#18). CNA #8 was observed sniffing throughout the observation, while CNA #8 was observed coughing into her hand. The cough had a wet vocal quality to it.

**F 880**

To ensure that the catheter tubing was not touching the floor.

Licensed nurses received education on facility procedure for blood glucose testing and medication pass observation completed for all nurses, identified issues were corrected and staff educated as needed.

#### 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.

Direct care staff have been educated by DON or designee regarding the requirements regarding the current infection control guidelines.

Upon hire and annually facility staff will receive facility provided infection control education to ensure understanding and competency.

#### 4. Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur.

The DON or designee will complete rounds and to ensure compliance with handwashing, meal service and hand sanitization, catheter tubing, and glucometer Rounds will be completed randomly 4 times weekly for 4 weeks, then 2 times weekly for 8 weeks. Identified concerns will be corrected at
### Summary Statement of Deficiencies

**F 880 Continued From page 96**

CNA #8 entered Resident #5's bathroom, applied soap to her hands, ran her hands under the water for 2 seconds before turning off the water, and dried her hands. CNA #8 placed a blanket on Resident #5's lap and combed his hair.

On 12/11/17 at 4:55 pm, CNA #8 was observed emptying Resident #51's catheter bag and disposing of her gloves. CNA #8 did not perform hand hygiene before placing a gait belt onto Resident #51's waist and transferring the resident into a wheelchair. CNA #8 brushed Resident #51's hair and filled her water cup without first performing hand hygiene. As CNA #8 left the room, she placed hand sanitizer onto her hands and rubbed her hands together for three seconds before stopping and wiping her hands on the pants of her uniform.

On 12/11/17 at 5:05 pm, CNA #8 was observed assisting Resident #78 with toileting. CNA #8 finished assisting Resident #78 and obtained an item the resident requested. CNA #8 then entered the bathroom, applied soap, ran her hands under the water for 3 seconds, turned the water off, and dried her hands. CNA #8 did not offer or assist Resident #78 with hand hygiene after the toileting.

On 12/12/17 at 9:33 am, CNA #5 was observed providing peri-care for Resident #5. The CNA applied barrier cream, disposed of her soiled gloves, obtained a clean pair of gloves, and then sanitized her hands. CNA #5 placed the new gloves under her arm while she sanitized her hands, and then placed the gloves on her hands.

On 12/12/17 at 9:43 am, CNA #5 and CNA #6

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**F 880**

the time identified, as possible & referred to DON for resolution.

Results of the rounds will be presented in the facility QAPI meeting for three months (or longer as necessary) beginning in February, with any identified negative trends addressed through system modification and staff education as appropriate.

5.) Date Corrective action will be completed: February 6, 2018
F 880 Continued From page 97

were observed entering Resident #59's room. CNA #5 donned gloves and assisted Resident #59 with peri-care, took her gloves off, and assisted Resident #59 put on undergarments without first performing hand hygiene.

On 12/12/17 at 10:56 am, Resident #59 stated she currently had a urinary tract infection. Resident #59 attributed the bladder infection to staff not responding to her call light in a timely manner and rushing through peri-care.

On 12/13/17 at 2:28 pm, Resident #59 said not all CNAs provide the same quality of peri-care. Resident #59 stated she felt some staff rushed through peri-care, some CNAs did thoroughly wipe, and some staff provided peri-care by wiping in both directions. Resident #59 raised her hand and demonstrated with quick motions of her hand going up and down.

On 12/15/17 at 11:39 am, the Assistant Director of Nursing (ADON) stated the proper procedure for peri-care care consisted of moving in a front to back direction, performing hand hygiene, changing gloves before applying a new incontinence brief, and hand hygiene upon the completion of cares. The ADON stated staff were to perform hand hygiene when transitioning from dirty to clean processes and between residents. The ADON stated the observations described above were not appropriate hand hygiene practices.

3. On 12/11/17 at 5:43 pm, CNA #17 was observed in the dining room for second floor residents who required staff assistance with meals. CNA #17 assisted several residents with
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<tr>
<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
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<tbody>
<tr>
<td>135098</td>
<td>A. BUILDING _____________________________</td>
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<td>B. WING ___________________________________</td>
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<tr>
<th>(X3) DATE SURVEY COMPLETED: 12/18/2017</th>
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**NAME OF PROVIDER OR SUPPLIER**

<table>
<thead>
<tr>
<th>STREET ADDRESS, CITY, STATE, ZIP CODE</th>
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<tbody>
<tr>
<td>VALLEY VIEW NURSING &amp; REHABILITATION</td>
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<tr>
<td>1140 NORTH ALLUMBAUGH STREET</td>
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<td>BOISE, ID 83704</td>
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<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tr>
<td>F 880</td>
<td>Continued From page 98 napkin placement and served water, juice, and coffee. While sitting on a wheeled stool, CNA #17 assisted multiple residents with bites of food. At one point, CNA #17 was observed touching a resident's silverware, his own face, and then other residents' silverware without washing his hands or using hand sanitizer throughout the dining observation. CNA #17 stated he &quot;sometimes&quot; used hand sanitizer. On 12/12/17 at 1:17 pm, Resident #15 stated he washed his hands once a day, but staff did not offer resident hand hygiene. Resident #15 said, &quot;I can't get night shift [staff] to leave me a washcloth.&quot; On 12/13/17 at 2:57 pm, Resident #31 stated staff did not provide hand hygiene before meals.</td>
<td>F 880</td>
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4. On 12/13/17 at 11:29 am, Licensed Practical Nurse (LPN) #1 was observed as she prepared to assess Resident #40's blood glucose (BG). In the resident's room, LPN #1 placed a glucometer used for multiple residents onto the resident's bedside table, obtaining gloves from the bathroom, putting on the gloves, picking up the glucometer and moving to the other side of the resident's bed where she then placed the glucometer on an over-the-bed table. The LPN did not use a barrier under the glucometer when it was on the resident's bedside- or over-the-bed tables. Upon completion of the BG assessment, LPN #1 picked up the glucometer, returned to the medication cart, placed the used glucometer on top of the medication cart without a barrier, removed her gloves, sanitized her hands, applied new gloves, cleaned the glucometer with a disinfecting wipe, and placed the clean...
### Statement of Deficiencies and Plan of Correction

**NAME OF PROVIDER OR SUPPLIER:**

**VALLEY VIEW NURSING & REHABILITATION**

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

**1140 NORTH ALLUMBAUGH STREET**

**BOISE, ID 83704**

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<th>(X5) COMPLETION DATE</th>
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**SUMMARY STATEMENT OF DEFICIENCIES**

(Each deficiency must be preceded by full regulatory or LSC identifying information)

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<td>F 880</td>
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<td>glucometer in the same spot on top of the medication cart where it had been before it was cleaned.</td>
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<td>On 12/13/17 at 5:25 pm, LPN #1 said she did not use a barrier when she assessed Resident #40's BG, or before and after she cleaned the glucometer at the medication cart. The LPN said she should have used a barrier each time.</td>
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<td>The facility's Blood Sampling-Capillary (Finger Sticks) policy directed staff to place the glucometer monitoring device on a &quot;clean field.&quot;</td>
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<td>5. On 12/13/17 at 11:37 am, LPN #1 was observed assessing Resident #72's BG. LPN #1 left the room, applied hand sanitizer from a hallway dispenser across from the resident's room and rubbed her hands together 3 times as she walked back to the medication cart. When asked if her hands were dry when she stopped rubbing them, LPN #1 asked, &quot;Are they supposed to be?&quot; When informed the sanitizer should be rubbed all over her hands until the sanitizer dried, LPN #1 said, &quot;Oh,&quot; and did not rub her hands any further.</td>
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<td>6. On 12/11/17 from 5:27 pm to 5:55 pm, Dietary Aide #2 was observed assisting residents in the second floor dining room with drinks. Dietary Aide #2 grasped the rims of multiple drink glasses for 9 residents with bare hands while filling and refilling residents' drinks and without performing hand hygiene. During the observations, Dietary Aide #2 touched the back of a resident's shirt and then served drinks to 3 residents, put a lid on on coffee cup while touching the drink opening,</td>
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Continued From page 100

F 880  

wiped his lips with his right hand and gave a coffee cup lid to another resident, shook a different resident's hand with both hands and refilled another resident's cup with juice, all without performing hand hygiene.

On 12/15/17 at 3:44 pm, the Certified Dietary Manager said staff should not touch the rim of glasses, sanitize hands after resident contact or with items they have touched, and practice appropriate hand hygiene. He also said there was a hand sanitizer pump on the wall in the dining room Dietary Aide #2 should have used.

7. Resident #86 was admitted to the facility on 9/18/17 with multiple diagnoses, including obstructive uropathy (blockage of the urinary tract).

A 9/18/17 Physician's Order documented Resident #86 had an indwelling Foley catheter.

On 12/12/17 from 1:43 pm to 1:53 pm, Resident #86 was observed in a wheelchair in the common area near the 200 hallway nurses station. Several inches of the resident's catheter tubing was on the vinyl floor of the common area as multiple staff walked by and did not reposition the tubing.

On 12/14/17 at 11:44 am, Unit Manager #1 said staff should have noticed the resident's catheter tubing was on the floor and addressed it accordingly.

F 883  

Influenza and Pneumococcal Immunizations  

CFR(s): 483.80(d)(1)(2)  

§483.80(d) Influenza and pneumococcal
### F 883 Continued From page 101

immunizations

§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-
(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident’s representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
   (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
   (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
### F 883

Continued From page 102

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and

(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.

This REQUIREMENT is not met as evidenced by:

Based on interview and review of the facility's Infection Control Procedure, it was determined the facility failed to develop and implement processes to minimize the risk of residents acquiring, transmitting, or experiencing complications from pneumococcal pneumonia. The facility failed to implement an immunization program that tracked residents' pneumococcal vaccine status so immunizations could be offered or provided as indicated. This was true for 5 of 5 residents (#'s 8, 27, 48, 75, and 91) sampled for the pneumococcal vaccination and had the potential to affect any resident over the age of 65 residing in the facility. Findings include:

The Centers for Disease Control and Prevention (CDC) website, updated 11/22/16, included recommendations for pneumococcal vaccination (PCV13 or Pneumovax23®) for all adults 65 years or older that documented:

* Adults 65 years or older who have not

**F883 Influenza & Pneumococcal Immunization**

1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

Res #8: Immunization record audited and reviewed with res and POA. Consent received to administer PPSV23, per CDC guidelines. Orders submitted, vaccine scheduled for 1/16/2018.

Res #27: Resident presented with risks vs benefits of pneumonia vaccine. As with previous offers, resident declines pneumonia vaccine.

Res #48: Immunization consents and administration record audited and
**F 883** Continued From page 103  
previously received PCV13, should receive a dose of PCV13 first, followed 1 year later by a dose of PPSV23.

"If the patient already received one or more doses of PPSV23, the dose of PCV13 should be given at least 1 year after they received the most recent dose of PPSV23."

The facility's Pneumococcal Vaccine policy, revised October 2014, directed staff to administer the pneumococcal vaccines or revaccination in accordance with current Centers for Disease Control and Prevention (CDC) recommendations. The policy documented that prior to or upon admission, residents would be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, offered the vaccine series within 30 days of admission to the facility unless medically contraindicated or the resident had already been vaccinated.

On 12/15/17 at 2:30 pm, the Infection Control Nurse and the Director of Nursing Services stated the facility followed CDC guidelines for pneumococcal vaccinations. When asked how the facility ensured residents' immunizations were completed to CDC guidelines, the Infection Control Nurse stated, "We are not there yet."

1. Resident #8 was admitted to the facility on 6/17/08 with multiple diagnoses, including diabetes mellitus.

The quarterly Minimum Data Set (MDS) assessment, dated 9/12/17, documented Resident #8's pneumococcal vaccination was current. Resident #8's clinical record identified reviewed with resident. Resident states that the consent, dated 11/24/17, is incorrect. Resident states the only pneumonia vaccine she has ever received was the PCV13 administered, by Valley View, on 11/8/2017. Risks vs benefits of PPVS23 discussed. Resident consents to administration of PPVS23 on 11/30/2018, which is in keeping with CDC guidelines. PPVS23 ordered and scheduled for 11/30/2018.

Res #75: Immunization consents and administration record was audited and reviewed with the resident and POA. Immunization record corrected to reflect administration of PPVS23 on 12/9/2016. Risks vs benefits of PCV13 discussed, consent received. PCV13 ordered and scheduled for 1/15/2018.

Res #91: Immunization consents and administration record was audited. Res consented to PCV13 on 10/7/2016 and received PCV13 on 11/7/2016. POA signed consent on 10/20/2017 for administration of PPVS23. Confirmed consent with POA on 1/10/2018. PPVS23 ordered and scheduled for 1/16/2018.

2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

Audit of all, current residents' immunization records, consent and
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<tr>
<td>F 883</td>
<td>Continued From page 104</td>
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</table>

she received the pneumococcal vaccine in 2007. The signed Pneumococcal Vaccine Informed Consent did not specify whether the pneumococcal vaccine the resident received in 2007 was PCV13 or PPSV23.

2. Resident #27 was admitted to the facility on 9/1/16 with multiple diagnoses, including peripheral vascular disease. The significant change of condition MDS assessment, dated 9/25/17, documented Resident #27 was not current with the pneumococcal vaccination. The facility provided a signed Immunization Consent which documented Resident #27 refused the pneumococcal vaccine on 9/9/16. There was no documented evidence in the record that the resident had been reapproached in 2016 or offered the immunization in 2017.

3. Resident #48 was admitted to the facility on 9/26/17 with multiple diagnoses, including congestive heart failure and pneumonia. The most recent MDS assessment completed for Medicare stay, dated 12/1/17, documented Resident #48 was current with her pneumococcal vaccination. The facility provided an Immunization Consent signed by Resident #48 on 10/3/17 for the PCV13 vaccine. An Immunization Consent, dated 11/24/17, documented Resident #48 declined the PCV13 immunization, however the immunization record documented Resident #48 received the PCV13 on 5/18/11.

administrations to be done on or before 2/6/18 to identify deficiencies, in accordance with CDC. Where appropriate, obtain consent or declination for scheduled vaccines. Obtain orders for the consented vaccine and administer.

3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.

• New immunization audit and tracking procedure in place.
• Staff Development Coordinator (SDC) will conduct ongoing weekly immunization audits.
  o All incoming residents will be assessed for immunization history and preference and added to audit.
• Facility will utilize CDC guidelines for vaccination.
• Consented vaccinations will be ordered and administered to consenting resident.
• Residents who refuse the pneumonia vaccine will be reoffered the pneumonia vaccine annually, resident/interested party may continue to decline the vaccine and the decline will be documented on the consent and filed in the resident’s medical record.

4.) Indicate how the corrective action(s) will be monitored to ensure the corrective
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<tbody>
<tr>
<td>135098</td>
<td>A. BUILDING:</td>
<td>12/18/2017</td>
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<td>B. WING:</td>
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</table>

**NAME OF PROVIDER OR SUPPLIER**

**VALLEY VIEW NURSING & REHABILITATION**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1140 NORTH ALLUMBAUGH STREET

BOISE, ID 83704

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
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<td><strong>F 883</strong> Continued From page 105</td>
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<td>4. Resident #75 was admitted to the facility on 3/10/15 with multiple diagnoses, including congestive heart failure and diabetes mellitus.</td>
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<td>A quarterly MDS assessment, dated 11/108/17, documented Resident #75 was current with the pneumococcal vaccination. The facility provided an Immunization Consent signed by Resident #75 on 10/13/16 consenting to the pneumococcal vaccine. The consent did not specify between the PCV13 and the PPSV23. The immunization record documented Resident #75 received the PCV13 on 12/9/16.</td>
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<td>5. Resident #91 was re-admitted to the facility on 9/13/17 with a diagnosis of diabetes mellitus.</td>
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<td>The Admission MDS assessment, dated 11/25/17, documented Resident #91 was current with the pneumococcal vaccination. The facility provided 3 Immunization Consents for Pneumococcal vaccine. One consent form was dated 10/7/16; another, dated 10/10/17, documented Resident #91 received the PCV13 immunization on 11/9/16; the third consent form was not dated.</td>
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<td>The facility's pneumococcal immunization process did not reflect current CDC recommendations or the facility's Infection Control Policy.</td>
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<td><strong>F 909</strong> Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails</td>
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<td>2/6/18</td>
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</table>

**F 909 2/6/18**

| F 883 action(s) are effective and compliance is sustained will not recur. | SDC will complete weekly audits, ongoing | Results of the audits will be presented in the facility QAPI meeting for three months (or longer as necessary) beginning in February, with any identified negative trends addressed through education and modification of the performance plan as appropriate. | 5.) Date Corrective action will be completed: February 6, 2018 |
Continued From page 106

and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, it was determined the facility failed to ensure side rails were inspected and maintained. This was true for 1 of 3 sampled residents and created the potential for harm if residents relied on loose mobility bars to prevent a fall from bed. Findings include:

Resident #15 was admitted to the facility on 6/2/17 with multiple diagnoses, including diabetes mellitus.

A quarterly Minimum Data Set (MDS) assessment, dated 9/19/17, documented Resident #15 required extensive assistance of at least 2 staff for bed mobility and was dependent on at least 2 staff for transfers.

On 12/12/17 at 10:37 am, a bariatric bed with a circular bar attached to each side of the frame near the head of the bed was observed in Resident #15's room. Each circular "mobility bar" was angled out and away from the bed. Both mobility bars were loose with approximately 3 inches of movement.

On 12/13/17 at 11:13 am, Resident #15 stated he could use the bars if he had someone reposition him onto his side. The mobility bars were not positioned where Resident #15 could use them independently and both mobility bars were loose with approximately 3 inches of movement.

F909 Resident Bed

1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

Resident #15 had his side rails tightened on 12-14-17.

2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

Other residents with side rails had their rails checked for tightness, if needed they were tightened upon discovery.

3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.

Side rails will be added to the daily rounds sheet for Department managers. If any side rails are found to be loose during the daily rounds, it will be reported to the Maintenance department immediately to be tightened. Maintenance has added...
<table>
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<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 909</td>
<td>Continued From page 107 movement.</td>
<td>F 909</td>
<td>checking side rails to their monthly preventative maintenance schedule.</td>
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<td>On 12/14/17 at 2:58 pm, the Physical Therapist stated she had not seen the resident in his bed and had not completed a safety assessment for Resident #15’s bed and mobility bars. The Physical Therapist stood near Resident #15’s bed and stated the bed was safe for the resident. Both mobility bars were loose with approximately 3 inches of movement.</td>
<td></td>
<td>4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur. Compliance with secure side rails will be reviewed in the facility monthly QAPI meeting. Any negative trends identified will be addressed and staff education as appropriate.</td>
<td>2/6/18</td>
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<tr>
<td>F 921 SS=E</td>
<td>Safe/Functional/Sanitary/Comfortable Environment CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain a safe and functional environment for residents. This was true for 2 of 20 (#15 and #37) sampled residents, 1 random (#94) resident and 1 of 7 residents in a group interview. This deficient practice had the potential affect all residents who ambulated in the hallways, dining rooms, and</td>
<td>F 921</td>
<td>F921 Safe/Functional/Sanitary/Comfortable Environment 1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. For residents #15, 37 and 94 the</td>
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<td>On 12/14/17 at 4:26 pm, the Maintenance Director stated the mobility bars were specific for the bed used by Resident #15. The Maintenance Director checked the mobility bars and stated, “They are loose.” The Maintenance Director stated he would tighten both bars.</td>
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<td>5.) Date Corrective action will be completed: February 6, 2018</td>
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<td>On 12/15/17 at 8:48 am, the side rails were observed tightly secured with no gaps between mattress and rails.</td>
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### SUMMARY STATEMENT OF DEFICIENCIES

**F 921 Continued From page 108**

Resident rooms and placed residents at risk for harm due to the potential for falls. Findings include:

1. On 12/11/17 at 6:05 pm, Resident #37 was observed unsuccessfully attempting to maneuver her wheelchair over the first-floor dining room threshold into the common area. An Admissions staff member asked the resident if she needed assistance, to which the resident agreed, and the staff member then propelled the wheelchair over the threshold.

2. On 12/12/17 at 9:01 am, Resident #94 was observed unsuccessfully attempting to self-propel her wheelchair over the first-floor dining room threshold into the common area. CNA #15 (Certified Nurse Assistant) assisted the resident over the threshold.

On 12/12/17 at 11:35 am, Resident #94 was observed unsuccessfully attempting to self-propel her wheelchair from the hallway into her room. The resident made 4 unsuccessful attempts before grabbing both sides of her room doorway and pulling herself on the wheelchair into the room.

On 12/12/17 at 3:26 pm, Resident #94 said there was a "bump" on the floor of her room doorway and in the dining room that she eventually "gets over," but would prefer more navigable thresholds.

3. On 12/12/17 at 3:00 pm, during a group interview, 1 of 7 residents in attendance stated thresholds throughout the facility were difficult to traverse in a wheelchair.

**F 921**

Thresholds are being replaced to accommodate easier maneuverability with the wheelchairs.

2.) How will you identify other residents having the potential to be affected by the same? Deficient practice and what corrective action(s) will be taken;

For other residents, the thresholds are being replaced to accommodate easier maneuverability over them for stated residents.

3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.

Department managers will monitor during dining duty for the ease of entrance into dining rooms. If issues are observed, they will be reported to Maintenance Department for resolution. Activities department will ask residents during monthly Resident Council regarding threshold passage. If issues are noted during the council meeting, they will be reported to Maintenance department for resolution.

4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and
F 921 Continued From page 109

4. Resident #15 was admitted to the facility on 6/2/17 with multiple diagnoses, including diabetes mellitus.

An Annual MDS assessment, dated 12/6/17, documented Resident #15 required extensive assistance of 1 staff with locomotion on- and off the unit, if in wheelchair. The resident was assessed as self-sufficient once in chair.

Resident #15 was observed self-propelling a wheelchair to- and from the dining room on multiple occasions.

On 12/15/17 at 3:37 pm, Resident #15 stated he can maneuver over thresholds in the hallway and dining room, but staff transporting him to the shower room in a shower chair was a "bumpy ride."

5. On 12/14/17 at 6:25 pm, the Housekeeping Supervisor was observed asking an unidentified resident if she needed help to get over "that mountain" coming out of the first-floor dining room.

On 12/15/17 at 4:12 PM, the Maintenance Director inspected the thresholds to the dining rooms and common areas of the facility and was informed of resident concerns. He said, "If it is a problem, then we need to fix it." He said the threshold could be lowered to allow residents to pass over more easily.

F 921 compliance is sustained will not recur. Resident council minutes regarding threshold concerns will be presented and reviewed for resolution during monthly QAPI meeting

5.) Date Corrective action will be completed: February 6, 2018
January 4, 2019

Randal Barnes, Administrator
Valley View Nursing & Rehabilitation
1140 North Allumbaugh Street
Boise, ID  83704-8700

Provider #:  135098

Dear Mr. Barnes:

On December 18, 2017, an unannounced on-site complaint survey was conducted at Valley View Nursing & Rehabilitation. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted December 11, 2017 through December 18, 2017.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007611

ALLEGATION #1:

The identified resident had changes in status and the resident's responsible party was not notified.

FINDINGS #1:

Several residents were observed throughout the survey for changes in status or condition. Staff were observed throughout the survey providing various care to residents.

The clinical record of the identified resident and several other residents' records were reviewed for quality of life, quality of care and resident rights concerns. The facility's Grievance file, the facility's Incident and Accident reports, the facility's Alleged Abuse reports, and Resident Council minutes from July 2017 through December 2017 were also reviewed.
Several residents and staff members were interviewed regarding change of condition, falls, change of cognition, emergency contacts, and resident rights. The Assistant Director of Nursing was interviewed regarding falls, change of cognition, emergency contacts, and resident rights.

The identified resident was interviewed and directed whom she wanted as her emergency contact.

The Incident and Accident files and the identified resident's clinical record documented she experienced multiple changes of condition where the emergency contact was not contacted.

Based on record review and staff interview, it was determined the allegation was substantiated and the facility was cited at F580.

CONCLUSIONS:

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

ALLEGATION #2:

Due to lack of staff, shower aides were pulled away from giving showers to residents in order to cover regular CNA duties, which left residents unkempt.

FINDINGS #2:

Based on observation, record review, resident and staff interview, it was determined the allegation was substantiated and the facility was cited at F677 and F725.

CONCLUSIONS:

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

ALLEGATION #3:

The identified resident was left by physical therapy sitting in her chair for more than 2 hours.

FINDINGS #3:

Several residents were observed before, during, and after physical therapy and no concerns were identified.

The facility's grievance file and Resident Council minutes were reviewed and concerns with physical therapy was not identified as an issue.
The identified resident stated there was no concern with physical therapy and she really enjoyed working with them.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

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

Sincerely,

Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj
January 3, 2019

Randal Barnes, Administrator
Valley View Nursing & Rehabilitation
1140 North Allumbaugh Street
Boise, ID 83704-8700

Provider #: 135098

Dear Mr. Barnes:

On December 18, 2017, an unannounced on-site complaint survey was conducted at Valley View Nursing & Rehabilitation. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted December 11, 2017 through December 18, 2017.

Several residents' fall precautions and call light response times were observed. Posted staffing sheets were also observed. In addition, several residents were observed for grooming, soiled incontinent briefs and meal tray placement in residents' rooms.

The clinical records of the identified resident and several other residents' records were reviewed for quality of care concerns. The facility's grievance file was reviewed, as well as its Incident and Accident reports and Resident Council minutes.

Several residents, CNAs and nurses were interviewed regarding various Quality of Life and Quality of Care issues. The Assistant Director of Nursing, Director of Nursing, and Administrator were also interviewed.

The complaint allegations, findings and conclusions are as follows:
Complaint #ID00007631

ALLEGATION #1:

An identified resident's bed was improperly placed, which resulted in the resident falling out of bed.

FINDINGS #1:

The identified resident was no longer in the facility at the time the complaint was investigated. Based on record review and staff interview, it was determined the allegation was substantiated and the facility was cited at F689.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

There was not enough staff to meet residents' needs.

FINDINGS #2:

Based on observation, record review, resident and staff interview, it was determined the allegation was substantiated and the facility was cited at F725.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

The daily staff posting was taken down during a specific period of time.

FINDINGS #3:

Daily staff sheets were observed to be posted each day, throughout the survey. Daily staff postings for the specific period of time were reviewed and no concerns were identified. The Administrator said the daily staff postings were hung up in the facility each day.

Based on observation, record review, and staff interview, it was determined the allegation could...
CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Due to lack of staff, shower aides were pulled away from giving showers to residents in order to cover regular CNA duties, which left residents unkempt.

FINDINGS #4:

Based on observation, record review, resident and staff interview, it was determined the allegation was substantiated and the facility was cited at F677 and F725.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #5:

An identified resident's incontinent brief was left soiled for an extended period of time.

FINDINGS #5:

Based on observation, record review, resident and staff interview, it was determined the allegation was substantiated for other residents and the facility was cited at F550 and F690.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #6:

An identified resident's meal tray was placed on the resident's bed and not placed on the bed tray table.

FINDINGS #6:
Several residents' rooms were observed for meal tray placement and no concerns were identified.

The facility's grievance file and Resident Council minutes were reviewed and meal tray placement was not identified as an issue.

Several residents said they had no concerns with their meal tray placement.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

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

Sincerely,

Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj
April 5, 2019

Randal Barnes, Administrator
Valley View Nursing & Rehabilitation
1140 North Allumbaugh Street
Boise, ID 83704-8700

Provider #: 135098

Dear Mr. Barnes:

On December 18, 2017, an unannounced on-site complaint survey was conducted at Valley View Nursing & Rehabilitation. The complaint allegations, findings and conclusions are as follows:

**Complaint# ID00007608**

**ALLEGATION #1:**

The Reporting Party said an identified resident's blood sugars were not controlled, that food with high sugar content and alcohol were provided, and the facility allowed blood sugars to go uncontrolled.

**FINDINGS #1:**

The complaint was investigated in conjunction with the federal recertification and State Licensure survey conducted at the facility from December 11, 2017 through December 11, 2017.

The identified resident was alert, oriented, and was his own responsible person.
The clinical record for the identified resident was reviewed, and no concerns were identified.

The identified resident said there were no concerns with his diabetic management.

The identified resident said that he did not receive alcohol from any source. He said his wife would bring in food that he requested. The identified resident said the facility attempted to provide alternatives to his request for foods with high sugar content, such as pecan pie but it was his choice.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The Reporting Party said an identified resident did not receive physical therapy as ordered.

FINDINGS #2:

The clinical record was reviewed for the identified resident and no concerns were identified. The identified resident said the insurance cancelled his therapy so he cancelled that insurance. The identified resident receives Physical Therapy 5 days a week. The identified resident had no concerns.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The Reporting Party said an identified resident was being discharged from the facility for failure to pay the facility.
FINDINGS #3:

The identified resident said he had no concerns regarding his financial status.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj