



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

April 8, 2016

Jeffrey Corriher, Administrator
Bridgeview Estates
1828 Bridgeview Boulevard,
Twin Falls, ID 83301-3051

Provider #: 135113

Dear Mr. Corriher:

On March 29, 2016, an on-site revisit follow-up of your facility was conducted to verify correction of deficiencies noted during the survey of December 4, 2015. In addition, a Complaint Investigation was conducted in conjunction with the on-site revisit. Bridgeview Estates was found to be in substantial compliance with federal health care requirements regulations as of March 30, 2016; however, your facility still has a deficiency that requires that require submission of a Plan of Correction.

Enclosed is a State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed.

NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 21, 2016**. The components of a Plan of Correction, as required by CMS must:

Jeffrey Corriher, Administrator
April 8, 2016
Page 2 of 2

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

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

- The administrator must sign and date the first page of the state licensure survey report, State Form.

The findings to the Complaint Investigation are being processed and will be sent to your facility under separate cover.

Your copy of the Form CMS-2567B, Post-Certification Revisit Report listing the deficiencies that have been corrected is enclosed.

Thank you for the courtesies extended to us during our on-site revisit. 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,



NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/pmt
Enclosures

RECEIVED

(# 3:00 SFH
M)

APR 20 2016

PRINTED: 04/07/2016
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2016
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NAME OF PROVIDER OR SUPPLIER
BRIDGEVIEW ESTATES

STREET ADDRESS, CITY, STATE, ZIP CODE
**1828 BRIDGEVIEW BOULEVARD
TWIN FALLS, ID 83301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during a complaint survey conducted at the facility from March 28, 2016 to March 29, 2016. The surveyors conducting the survey were: Evelyn Floyd, JD, MS, RN Ann Monhollen, MSN, RN Definitions Included: RN = Registered Nurse	C 000	<i>This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The Plan of Correction does not constitute an admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.</i>	
C 762	02.200.02,c,ii When Average Census 60-89 Residents ii. In SNFs with an average occupancy rate of sixty (60) to eighty-nine (89) patients/residents a registered professional nurse shall be on duty for each a.m. shift (approximately 7:00 a.m. - 3:00 p.m.) and p.m. shift (approximately 3:00 p.m. to 11:00 p.m.) and no less than a licensed practical nurse on the night shift. This Rule is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to provided the required RN staff coverage for 4 of 21 days reviewed for staffing. This failure had the potential to affect all residents in the facility. Findings include: Review of staffing records from 3/6/2016 to 3/26/2016 documented 4 days: 3/13/2016; 3/16/2016; 3/20/2016; and 3/26/2016 not to have an RN on duty during the day and evening shifts as required for a facility with an average census of 60 to 89 residents.	C 762	STATE CITATIONS C-762 SPECIFIC RESIDENT None. OTHER RESIDENTS All residents who reside in the building have the potential to be affected. When census is 60-89 an RN will be on duty for day (6am-2pm) and evening (2pm-10pm) shifts.	

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APR 20 2016
FACILITY STANDARDS

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

[Signature] 4-18-16 *Executive Director*

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2016
NAME OF PROVIDER OR SUPPLIER BRIDGEVIEW ESTATES		STREET ADDRESS, CITY, STATE, ZIP CODE 1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 762	Continued From page 1 On 3/30/2016, the Vice President of Operations stated the facility was aware of the RN issue and the corporate recruiter was working on hiring more RNs.	C 762	<p>SYSTEMIC CHANGES</p> <p>Staff in-serviced on ensuring that when census is at 60-89 an RN must be on duty for day (6am-2pm) and evening (2pm-10pm) shifts. Staff in-serviced that if an RN cannot be found prior to shift they must inform the Director of Nursing.</p> <p>MONITOR</p> <p>Director of Nursing will audit the schedule two times weekly for two months, weekly times two months and monthly times two months to ensure there is RN coverage for day (6am-2pm) and evening (2pm-10pm) shifts when census is 60-89.</p> <p>Audits will be brought through Quality Assurance monthly and trends will be identified and education provided</p> <p>COMPLIANCE DATE: 4/21/16</p>	



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May 20, 2016

Jeffrey Corriher, Administrator
Bridgeview Estates
1828 Bridgeview Boulevard,
Twin Falls, ID 83301-3051

Provider #: 135113

Dear Mr. Corriher:

On **March 29, 2016**, an unannounced on-site complaint survey was conducted at Bridgeview Estates. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007229

The complaint survey was conducted from March 28, 2016 to March 29, 2016.

The following observations were conducted:

Response to residents' call lights, assistance, and needs;
Staffing adequacy; Environment and cleanliness; and Assistive devices.

The following documents were reviewed:

The medical records of the identified resident and 7 other residents;
The facility grievance file from January 2016 - March 2016;
Resident Council Meeting minutes from January 2016- March 2016;
Admission and Discharge policies and records from January 2016- March 2016;
Infection control policies and records; and Staffing records.

The following interviews were conducted regarding quality of care issues and resident rights:
Residents and family members;
Facility staff; and Facility's Inter-Disciplinary Team members.

Allegation #1: The reporting party alleged that when staff toileted the identified resident, staff "yanked down" the resident's pants and remained in bathroom to watch.

Findings #1: The identified resident was no longer residing in the facility at the time the complaint was investigated. The identified resident's medical record contained documentation the resident was a high fall risk and required assistance for transfers and toileting. The record did not contain documented evidence the identified resident or family members had voiced concerns with staff toileting the resident. Interviews with staff revealed that depending on the resident risk factors, remaining with a resident while toileting may be appropriate.

Based on review of the identified resident's medical record and interviews, it was determined the facility was in compliance with Federal guidelines.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The reporting party alleged the bathroom was unclean and the call identified resident's walker and call light had blood on them.

Findings #2: The identified resident's medical record did not contain documentation regarding cleanliness of the resident's room. Review of the grievance records did not contain issues with facility cleanliness. Resident interviews did not reveal issues with cleanliness. The general facility and resident rooms were observed for cleanliness.

Based on review of the identified resident's medical record, grievances, interviews and observations, it was determined the facility was in compliance with Federal guidelines.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The reporting party alleged the identified resident did not receive pain medication, vital signs, dressing changes, ice for her knee, continuous passive motion machine (CPM), or a trapeze for her bed.

Findings #3: The identified resident's medical record contained orders for pain medication, CPM, and a trapeze over her bed. A pain assessment on admission documented the resident denied having any pain. Subsequent pain assessments during the evening and night shifts on the day of admission, documented the resident rated her pain at "5." However, the medication administration record (MAR) documented the resident did not receive any pain medication until the following day. Admission orders documented the resident's dressing was not to be changed for two weeks, however when the dressing became wet after a shower the dressing was appropriately changed.

The medical record contained documentation that vital signs were taken and the resident had received a trapeze for bed mobility, and was using a CPM machine. Interviews with nursing staff revealed that application of ice packs would be a nursing intervention and not necessarily require a physician's order.

Substantiated. According to the identified resident's medical record, the administration of pain medication was delayed. However, delay of the trapeze, CPM machine, and ice packs could not be confirmed. The facility was cited at F 309 during recertification and the complaint survey on March 28 to March 29, 2016 and the facility was not back in substantial compliance at the time of the allegation.

Conclusion #3: Substantiated. No deficiencies related to the allegation are cited.

Allegation #4: The reporting party alleged staff did not respond to call lights in a timely manner to meet the identified resident's needs and the night shift was understaffed.

Findings #4: The identified resident was no longer at the facility during the complaint investigation. Staffing records did not contain documented evidence the night shift was understaffed. Review of the grievance records and Resident Council Meeting minutes did not contain multiple complaints or a pattern of complaints regarding call lights. Response to call lights was observed during the complaint investigation. Resident interviews did not reveal issues with call light response or resident needs not being met by the facility staff.

Based on review of facility records, observations and interviews, it was determined the facility was in compliance with Federal guidelines.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: The reporting party alleged the facility food was not palatable and "horrible."

Findings #5: The grievance records and Resident Council Meeting minutes did not contain documentation the food was not palatable. A meal test tray was conducted during the complaint investigation. Interviews with residents did not reveal issues with food palatability.

Based on record reviews, interviews and food testing for palatability, it was determined the facility was in compliance with Federal guidelines.

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: The reporting party alleged the identified resident was moved to another room because her former roommate had a transferable infection.

Jeffrey Corriher, Administrator
May 20, 2016
Page 4 of 4

Findings #6: The identified resident's medical record and the roommate's medical record documented the roommate had been transferred to another room and placed on infection control precautions. Review the facility's infection control policy revealed the facility had acted in accordance with the policy.

Substantiated. According to the medical records and facility policies, the facility acted appropriately. No deficiencies cited.

Conclusion #6: Substantiated. No deficiencies related to the allegation are cited.

Two of the allegations were substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive, slightly slanted style.

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt



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May 19, 2016

Jeffrey Corriher, Administrator
Bridgeview Estates
1828 Bridgeview Boulevard,
Twin Falls, ID 83301-3051

Provider #: 135113

Dear Mr. Corriher:

On **March 29, 2016**, an unannounced on-site complaint survey was conducted at Bridgeview Estates. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007247

The complaint survey was conducted from March 28, 2016 to March 29, 2016.

During the survey staff were observed for call light response times and resident transfers with one and two person assistance, and the nurse and cna staffing hours were reviewed. The following documents were reviewed: The medical records of the identified resident and 7 other residents, the facility's grievance file from January 2016 - March 2016; Resident Council Meeting minutes from January 2016- March 2016; Admission and Discharge policies and records from January 2016- March 2016; and the visitation policy.

The following interviews were conducted regarding quality of care issues and resident rights: Residents and family members; facility staff; and the facility's Inter-Disciplinary Team members.

Allegation #1: The reporting party alleged the family was initially denied the right to stay with the identified resident overnight.

Findings #1: The identified resident was no longer residing in the facility at the time of the complaint investigation. Review of the resident's admission and medical records did not contain documentation regarding issues with visitation or family. Review of facility grievance records did not contain visitation issues. Review of the admission policies and corporate visitation policy documented visiting privileges and restrictions are designed to meet the resident needs. During interviews with facility staff, staff stated the facility had a "24/7" visitation policy and the facility tried to accommodate families to meet the resident's needs. Interviews with residents revealed family members could visit anytime.

Based on the identified resident's medical records, grievances, facility policies, and interviews, it was determined the facility was in compliance with Federal guidelines.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The reporting party alleged the facility did not have adequate staff for the residents and call lights were not answered in a timely manner.

Findings #2: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure there was adequate staffing to provide for the needs and well-being of residents who required a restorative nursing program. This affected 4 of 14 (#s 3, 6, 7, & 13) sampled residents and had the potential to affect all residents who were at risk for developing a functional decline. This failure created the potential for physical decline if residents did not receive restorative services. Findings included:

On 12/2/15 at 9:05 am, CNA #9 said she formerly assisted residents with the Restorative Nursing Assistant (RNA) program, but had been reassigned several months prior to perform other duties due to lack of staff.

On 12/3/15 at 10:25 am, PTA #9 said he would refer residents to the RNA program if one would have been one in place.

On 12/3/15 at 2:45 pm, Occupational Therapist #10 said she would recommend several residents to the RNA program, but the facility did not have an RNA program due to lack of staffing.

Conclusion #2: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #3: The reporting party alleged the identified resident was receiving antibiotic therapy for a urinary tract infection (UTI), had bladder spasm, and was in pain. The facility did not report the bladder spasm to the physician or follow up on the pain complaint.

Findings #3: Review of the identified resident's medical record documented the resident did have a UTI, and was on antibiotics. The resident was on regular pain medication for a hip fracture. The medical record did not contain documented evidence the resident was experiencing bladder spasms or that the pain medication was ineffective requiring physician notification.

Based on the identified resident's medical record, it was determined the facility was in compliance with Federal guidelines.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: The reporting party alleged the identified resident required extensive assistance of two persons for mobility, transfers and toileting. The resident was observed transferred with one person assistance instead of two person assistance.

Findings #4: Review of the identified resident's medical records contained documentation the resident did require extensive assistance of two persons for bed mobility, transfers, and toileting. Review of the resident's Incident and Accident reports (I&A), documented the resident had two falls unrelated assistance by facility staff. Observation of transfers and toileting of residents by facility staff during the survey did not reveal inappropriate care.

Based on review of the identified resident's medical records and observations, it was determined the facility was in compliance with Federal guidelines.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: The reporting party alleged the identified resident was over medicated and inadequately medicated for pain. The resident was not able to verbalize pain and family had to request pain medication when the resident displayed non-verbal signs and symptoms of pain.

Findings #5: Review of the identified resident's medical record contained documented evidence the resident had orders for pain medication. Medication Administration Records (MAR), documented the resident received pain medication approximately every four hours, which was effective. Physician orders documented the resident's pain medication had been changed several times. Progress Notes documented family members reporting the effectiveness of pain medication for the resident.

Based on the identified resident's medical records, it was determined the facility was in compliance with Federal guidelines.

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

Jeffrey Corriher, Administrator
May 19, 2016
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Allegation #6: The reporting party alleged the identified resident was a high risk for falls and the resident's bed was placed in a low position with a mat to the floor. The resident was found on the floor mat on three occasions and the nurse did not perform focused assessments after the falls.

Findings #6: The identified resident's medical records documented the resident was a high risk for falls and interventions included a low bed and a mat beside the bed on the floor. Review of the resident's Incident and Accident reports (I&A), documented the resident had rolled out of bed onto the floor mat while a family member was present. The I&A's contained documented evidence the resident was assessed after each incident.

Substantiated. According to the identified resident's medical record, the resident had rolled out of bed onto the mat beside the bed on two occasions without injury.

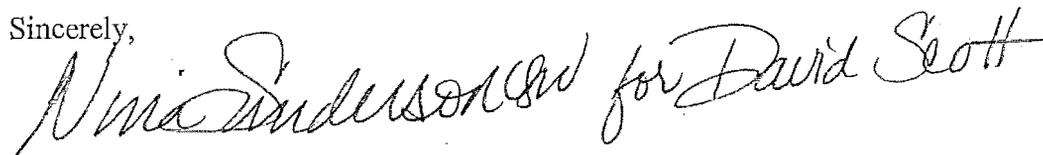
However, the low bed and mat placed on the floor were appropriate interventions and the resident was assessed for injuries according. No deficiencies were cited.

Conclusion #6: Substantiated. No deficiencies related to the allegation are cited.

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 questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt