



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

September 28, 2016

Michael Crowley, Administrator
River's Edge Rehabilitation & Living Center
714 North Butte Avenue
Emmett, ID 83617-2725

Provider #: 135020

Dear Mr. Crowley:

On **September 9, 2016**, a survey was conducted at River's Edge Rehabilitation & Living Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

Michael Crowley, Administrator
September 28, 2016
Page 2 of 4

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 10, 2016**. Failure to submit an acceptable PoC by **October 10, 2016**, may result in the imposition of penalties by **October 10, 2016**.

The components of a Plan of Correction as required by CMS must:

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **October 14, 2016 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **December 8, 2016**. A change in the seriousness of the deficiencies on **October 24, 2016**, may result in a change in the remedy.

Michael Crowley, Administrator
September 28, 2016
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **December 8, 2016** includes the following:

Denial of payment for new admissions effective **December 8, 2016**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 8, 2017**, 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 **December 8, 2016** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

Michael Crowley, Administrator
September 28, 2016
Page 4 of 4

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

- BFS Letters (06/30/11)

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

This request must be received by **October 10, 2016**. If your request for informal dispute resolution is received after **October 10, 2016** the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

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

David Scott, RN, Supervisor
Long Term Care

DJS/lj
Enclosures

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

PRINTED: 10/19/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/09/2016
NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from September 6, 2016 to September 9, 2016.</p> <p>The surveyors conducting the survey were:</p> <p>Linda Kelly, RN, Team Coordinator Lorinda Schreier, RN Marcia Mital, RN</p> <p>Survey Definitions: ADL = Activities of Daily Living CHF = Congestive Heart Failure COPD = Chronic Obstructive Pulmonary Disease DNS = Director of Nursing Services L = Liters LPM = Liters per minute NC = Nasal cannula O2 = Oxygen O2 sat = Oxygen saturation LN = Licensed Nurse TED hose = Stockings used to reduce edema or swelling in the legs and prevent blood clots or thromboembolic disease.</p>	F 000			
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 282		10/14/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/06/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/09/2016
NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 1</p> <p>Based on observation, record review and staff interview, it was determined the facility failed to ensure residents' plans of care were followed related to arm protectors for 1 of 2 sample residents with arm protectors (#6) and 1 sample resident (#11) with Ted hose (stockings to reduce swelling in lower extremities). This deficient practice placed Resident #6 at risk of additional injury to her arms due to lack of protective coverings, and Resident #11 at risk of pain and discomfort due to leg or foot swelling, and further skin complications. Findings include:</p> <p>1. Resident #6 was admitted to the facility with diagnoses that included Alzheimer's disease and failure to thrive.</p> <p>Resident #6's care plan, dated 9/6/16, documented a skin tear to the right forearm, which was covered by the facility with "derma savers" arm protectors.</p> <p>Recapitulated physician orders, dated 8/30/16, documented staff were to ensure the arm protectors were in place each shift whenever Resident #6 was out of bed.</p> <p>Resident #6 was observed sitting in a Broda chair with no arm protectors on 9/8/16 at 12:20 pm, 1:05 pm, 3:14 pm, and 4:23 pm.</p> <p>On 9/9/16 at 9:46 am, CNA #2 said staff put the arm protectors on the resident's arms when they got Resident #6 out of bed.</p> <p>2. Resident #11 was admitted to the facility with diagnoses that included CHF, dementia and hypertension.</p>	F 282	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, River's Edge Rehabilitation and Living Center does not admit that the deficiencies listed on this form exists, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, facts, and conclusions that form the basis for the deficiencies.</p> <p>F282: SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>Resident #6 is now using the arm protectors when out of bed. Resident #11 is now using the Ted hose during the day.</p> <p>Corrective action for resident that may be affected by this deficiency:</p> <p>All Residents that are care planned for the use of protective and adaptive equipment have the potential to be</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/09/2016
NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 2 Resident #11's care plan, dated 6/27/16, documented she required "extensive" assistance from staff for dressing and putting on the TED hose, which were to be on during the day and off at bedtime. Resident #11 was observed without TED hose on 9/8/16 at 8:57 am, 12:21 pm, 12:42 pm, and 4:02 pm, and on 9/9/16 at 9:17 am. On 9/9/16 at 9:19 am, LN #4 said CNAs put Resident #11's TED hose on in the morning when they get her up from bed. Resident 11 was observed up and out of bed on 9/9/16 at 9:20 am, with LN #4 present, without the TED hose.	F 282	effected by this deficient practice and will be reviewed and observed to ensure that they are receiving services provided by the facility by qualified persons in accordance with their written plan of care. Measures that will be put into place to ensure that this deficiency does not recur: DON, SDC or designee will educate the CNAs and LNs on the requirement to ensure that services provided or arranged by the facility must be provided by qualified persons in accordance with each residence written plan of care. Education will be completed by 10/14/16. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: The DON, SDC or designee will conduct audits observing that Residents are being provided services in accordance with their written plan of care. The audits will be conducted 3 times per week on varying shifts for 1 month, then once a week on varying shifts for 2 months to ensure compliance. Audits will begin the week of 10/17/16. The DON will review and report the results of the audits monthly in QA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/09/2016
NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	Continued From page 3	F 282	committee meeting. The QA committee will make a determination after 3 months on continuing the audits.		
F 328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure O2 was administered as ordered and O2 tubing was changed per policy for 2 of 5 sample residents (#10 and #11) reviewed for O2 use. The failures placed the residents at risk for subtherapeutic benefit from the oxygen and increased risks for side effects or complications. Findings include:</p> <p>1. Resident #10's physician orders for September 2016 included O2 via NC continuously at 2 - 3 liters to keep O2 saturations at 88% or greater related to CHF.</p>	F 328	<p>Corrective action completed by: 10/14/16</p> <p>F328: TREATMENT/CARE FOR SPECIAL NEEDS:</p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>Resident #10 has tubing that meets the facilities <input type="checkbox"/> replacement policy standard of being replaced every 7 days.</p> <p>Resident #11 is receiving O2 in accordance with physician orders.</p>	10/14/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/09/2016
NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 328	<p>Continued From page 4</p> <p>On 9/8/16 at 9:05 am and 12:25 pm, Resident #10 was observed with a portable O2 tank attached to the back of her wheelchair. The O2 tubing was observed with a tape tag dated 8/21/16.</p> <p>The facility's Oxygen Equipment Policy documented staff were to replace O2 tubing every 7 days.</p> <p>On 9/8/16 at 12:40 pm, LN #1 stated Resident #10's O2 tubing, as indicated by the tape tag dated 8/21/16, was over due for replacement per the facility's 7-day replacement policy.</p> <p>2. Resident #11 was admitted to the facility with diagnoses that included CHF, dementia and hypertension.</p> <p>Resident #11's recapitulated physician orders, dated 8/30/16, documented staff were to provide O2 at 2 LPM via NC.</p> <p>Resident #11 was observed on 9/8/16 at 8:58 am and 9:48 am, with her oxygen concentrator set at 3 liters per minute.</p> <p>Resident #11 was observed on 9/8/15 at 9:50 am, with LN #5 present, with the O2 concentrator set at 3 LPM. LN #5 said the O2 should be at 2 liters and LN #6 adjusted the concentrator to 2 LPM.</p>	F 328	<p>Corrective action for resident that may be affected by this deficiency:</p> <p>All Residents with O2 orders have the potential to be effected by this deficient practice and were observed to ensure that physician orders are being followed and the tubing is in compliance with the facility policy on 9/15/16.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>DON, SDC or designee will educate the CNAs and LNs on the requirement to ensure that O2 is administered as ordered and that O2 tubing must be changed every 7 days per policy. Education will be completed by 10/14/16.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The DON, SDC or designee will conduct audits observing that Residents with O2 orders are receiving O2 as ordered and that the O2 tubing is changed per policy. The audits will be conducted 3 times per week on varying shifts for 1 month, then once a week on varying shifts for 2 months to</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/09/2016
NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 328	Continued From page 5	F 328	ensure compliance. Audits will begin the week of 10/17/16.		
F 371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure kitchen equipment, shelves, drawers, storage bins, carts, pans, and can opener, were clean and sanitary. This deficient practice had the potential to adversely affect 43 of 43 residents who consumed food prepared in the kitchen. Findings include: On 9/7/16 at 12:40 pm, with the Dietary Manager present, the following was observed:</p>	F 371	<p>The DON will review and report the Results of the audits monthly in QA committee meeting. The QA committee will make a determination after 3 months on continuing the audits.</p> <p>Corrective action completed by: 10/14/16</p> <p>F371: FOOD PROCEDURE, STORE/PREPARE/SERVE-SANITARY: Corrective action for residents found to have been affected by this deficiency: No specific residents were identified as being affected by this deficiency. The cookie sheets that had a dark</p>	10/14/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/09/2016
NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 6 * A dark brown/black substance on the bottom and inside corners of a cookie sheet on a shelf under the prep table; a sticky yellow brown substance on the shelf where the cookie sheets were stored under the prep table; a black/brown build up with food particles on the can opener knife and the can opener holder attached to the prep table; and a brown substance on the top of the bowl and plate warmer. * Food particles and dirt on the bottom of the drawer where the spatulas and knives were stored; the bottom of the bowl storage container; the top and bottom drawers below the small mixer; and in the pan used to store lids on the shelf under the steam table. * Brown food particles and a yellow sticky substance on the front and sides of the mixer stand, and white food splatters on the underside where the beaters attached to the big mixer. * A build-up of dust and food particles on the cart top where the mixer was sitting; on the shelf of the cart where the mixer was sitting; and on the shelf under the steam table. * A build-up of dust and dirt on the top of the flour storage container; the top of the sugar storage container; the shelf above the stove where pans were stored; the utensil rack above the large mixer; and the side of the prep table. During the observation, the Dietary Manager stated there were sanitation problems in the kitchen.	F 371	brown/black substance were discarded and replaced with new ones on 9/16/16. The shelves under the prep table were cleaned on 9/12/16. The can opener and prep table were cleaned on 9/12/16. The bowl and plate warmer was cleaned on 9/12/16. The drawer where the spatulas and knives are stored was cleaned on 9/12/16. The bottom of the bowl storage container and the top and bottom drawer below the mixer were cleaned on 9/12/16. The pan used to store lids under the steam table were cleaned on 9/12/16. The mixer stand and the underside where the beaters attach to the big mixer was cleaned on 9/12/16. The cart tops were all cleaned on 9/12/16. The shelves in all of the carts were cleaned on 9/12/16. The shelf under the steam table was cleaned on 9/12/16. The flour storage container was cleaned on 9/12/16. The sugar storage container was cleaned on 9/12/16. The shelf above the stove where the pans are stored was cleaned on 9/12/16. The utensil rack above the large mixer was cleaned on		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/09/2016
NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 7 The facility's Dietary, Sanitation Policy documented, "It is the policy of this facility that the food service area shall be maintained in a clean and sanitary manner."	F 371	<p>9/12/16. The side of the prep table was cleaned on 9/12/16.</p> <p>Corrective action for resident that may be affected by this deficiency:</p> <p>All Residents have the potential to be effected by this deficient practice.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>DON, Administrator or designee will educate the dietary staff on the requirement to (1) procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions. Education will be completed by 10/14/16.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The ED, DON or designee will conduct audits observing that the facility is meeting the federal requirement to (1) procure food from sources approved or considered satisfactory by Federal,</p>	

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

PRINTED: 10/19/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/09/2016
NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 8	F 371	<p>State, or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions. The audits will be conducted 3 times per week on varying shifts for 1 month, then once a week on varying shifts on an ongoing basis.</p> <p>Audits will begin the week of 10/17/16. The Administrator will review and report the results of the audits monthly in QA committee meeting.</p> <p>Corrective action completed by: 10/14/16</p>		



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 21, 2017

Michael Crowley, Administrator
River's Edge Rehabilitation & Living Center
714 North Butte Avenue
Emmett, ID 83617-2725

Provider #: 135020

Dear Mr. Crowley:

On **September 9, 2016**, an unannounced on-site complaint survey was conducted at River's Edge Rehabilitation & Living Center. The complaint was investigated in conjunction with the facility's federal recertification and State licensure survey conducted September 6, 2016 to September 9, 2016.

Throughout the survey, eleven individual residents and all residents in general, were observed for quality of life and quality of care concerns. Two meal services were observed in both dining rooms and in resident rooms. Three individual residents who were identified as denture wearers were specifically observed during both meal services. In addition, a Certified Nursing Assistant was observed while providing oral care/denture care for an individual resident.

The clinical records of the identified resident and thirteen other residents were reviewed for quality of life and quality of care issues. The facility's grievance files, Incident and Accident reports, Resident Council meeting minutes and investigations of allegations of abuse were also reviewed.

Interviews were conducted with four individual residents, two family members and a group of twelve residents. Several Licensed Nurses and Certified Nursing Assistants were interviewed, as were the Director of Nursing Services and the Administrator.

The complaint allegations, findings and conclusions are as follows:

Michael Crowley, Administrator
April 21, 2017
Page 2 of 2

Complaint #ID00006988

ALLEGATION #1:

The facility failed to use a new denture adhesive for an identified resident even though it was available. The resident started to choke and was taken to an emergency department where an endoscopy was performed to retrieve a piece of bacon from his/her esophagus.

FINDINGS:

Interviews with residents, family members and the nursing staff, and record reviews, determined there were no voiced or written concerns that denture adhesive was not being used.

The staff implemented choking and aspiration precautions and three residents who wore dentures did not have problems eating their food during the meal services. A Certified Nursing Assistant provided appropriate oral/denture care, including denture adhesive, for one resident and she was able to state how to provide appropriate oral and denture care.

The identified resident's clinical record documented a history of esophageal stricture and stenosis and previous dilations. The resident left with family at 8:25 am on the morning in question and the facility was contacted by a local emergency department around 12:00 pm (noon). The resident returned to the facility around 9:00 pm after an endoscopy to remove a piece of bacon. There was no documented evidence, however, that the resident's dentures had not been secured that morning.

There was a lack of sufficient evidence to identify deficient practice, therefore the complaint 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.

Sincerely,

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

David Scott, R.N., Supervisor
Long Term Care

Michael Crowley, Administrator
April 21, 2017
Page 3 of 2

DS/lj



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 21, 2017

Michael Crowley, Administrator
River's Edge Rehabilitation & Living Center
714 North Butte Avenue
Emmett, ID 83617-2725

Provider #: 135020

Dear Mr. Crowley:

On **September 9, 2016**, an unannounced on-site complaint survey was conducted at River's Edge Rehabilitation & Living Center. The complaint was investigated in conjunction with the facility's federal recertification and State licensure survey conducted September 6, 2016 to September 9, 2016.

Immediately after entering the facility, the survey team conducted a general tour of residents' rooms and common areas. Throughout the survey, twelve individual residents, and all residents in general, were observed for quality of life issues, including appropriate clothing, and quality of care concerns, including signs of distress. In addition, facility staff were observed as they provided care, interacted with residents and responded to residents' needs and requests.

The clinical records of the identified resident and thirteen other residents were reviewed for quality of life and quality of care issues, including change in condition and notification of appropriate parties. The facility's grievance files, Incident and Accident reports, Resident Council meeting minutes and investigations of allegations of abuse were also reviewed.

Interviews were conducted with three individual residents, two family members and a group of twelve residents. Several direct care staff, including nurses and nurses' aides, were also interviewed, as were the Director of Nursing Services, Social Worker and Administrator. The interviews included questions about residents' rights, including notification of appropriate parties, quality of life and quality of care issues.

Michael Crowley, Administrator
April 21, 2017
Page 2 of 4

Based on interviews with residents and family members, and record reviews, there were no voiced or written concerns that staff minimized residents' condition, delayed care related to changes in condition or delayed access to emergency services when it was needed or requested. Throughout the survey, staff were observed as they provided care, communicated with residents and/or family members and promptly attended to residents' needs and requests.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007317

ALLEGATION #1:

The facility downplayed the seriousness of an identified resident's illness and did not assist the resident to access emergency services when it was requested which caused the resident to suffer needlessly prior to his/her death.

FINDINGS:

The clinical record documented the facility monitored the identified resident's condition and promptly reported changes to the physician. The record documented the physician initially ordered an expectorant and oxygen then added an antibiotic a day later. The record documented the resident refused the oxygen several times, including the day s/he went to an emergency room. The record documented the resident was sent to the emergency room five minutes after it was requested and interviews with staff verified that.

Deficient practice was not identified and the complaint could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility did not inform an interested party "quickly enough" that an identified resident was ill and did not provide notice to the interested party until four hours after an antibiotic was not started .

FINDINGS:

The identified resident's clinical record documented nasal congestion and a low grade temperature one day. The fever resolved with acetaminophen and the resident was able to use an

electric wheelchair for mobility and go outside for fresh air. Five days later, "sinus congestion" and an intermittent, moist non-productive cough developed but the resident remained afebrile. Increased fluid intake was encouraged and the facility monitored for upper respiratory infection. Four days later, lethargy and a low grade fever was noted and reported to the physician. An expectorant and over-the-counter type medication was ordered. The next day, "thick sputum" developed but the resident was able to expectorate the sputum with encouragement to cough forcibly. The resident was alert and oriented during this time, but frequently refused supplemental oxygen ordered by the physician. The resident's oxygen saturation level was 82% on room air but increased to 89% when the resident agreed to use oxygen. The physician was updated again and the next morning a daily oral antibiotic and oxygen saturation monitoring every three hours was ordered. The interested party was notified at that time. The antibiotic was administered for two days. However, the resident repeatedly refused the oxygen and said, "No I am not going to wear that thing. ((###) mask) I don't need it." The interested party was present and asked the facility to send the resident to the emergency room, which they did.

Based on the interviews and record reviews, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility dressed an identified resident in someone else's pants, which were much too small and much too short.

FINDINGS:

Twelve individual residents and all residents in general were observed in appropriate clothing throughout the survey.

Residents and family members interviewed did not voice any concerns that residents were dressed in ill-fitting clothes or someone else's clothes and there were no written concerns to that effect either.

The identified resident's clinical record did not contain documentation the resident was dressed inappropriately or in someone's clothes.

Based on observations, interviews and record reviews, the allegation could not be substantiated.

Michael Crowley, Administrator
April 21, 2017
Page 4 of 4

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.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The "D" is large and stylized, and "Scott" is written in a cursive-like script.

David Scott, R.N., Supervisor
Long Term Care

DS/lj