



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR  
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3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
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January 27, 2017

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

Provider #: 135068

Dear Mr. Lewis, Jr.:

On **January 13, 2017**, a survey was conducted at Parke View Rehabilitation & Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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 **February 6, 2017**. Failure to submit an acceptable PoC by **February 6, 2017**, may result in the imposition of penalties by **March 3, 2017**.

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 **February 17, 2017 (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 **April 13, 2017**. A change in the seriousness of the deficiencies on **February 27, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **April 13, 2017** includes the following:

Denial of payment for new admissions effective **April 13, 2017**. [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 **July 12, 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 **April 13, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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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 **February 6, 2017**. If your request for informal dispute resolution is received after **February 6, 2017**, 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, appearing to read "David Scott for". The signature is written in a cursive style.

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

DS/lj

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

PRINTED: 02/10/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135068</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/13/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARKE VIEW REHABILITATION &amp; CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2303 PARKE AVENUE BURLEY, ID 83318</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from January 9, 2017 to January 13, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Presie C. Billington, RN Marci Claire, RN David Scott, RN Caroline Carter, RD</p> <p>Survey definitions:</p> <p>ADL - Activities of Daily Living AKA - Above the Knee Amputation BID - Twice Daily CNA - Certified Nursing Assistant C/O - Complaint Of D/T - Due To IR - Internal Rotation LLE or lle - Left Lower Extremity LN - Licensed Nurse LPM - Liters per Minute MDS - Minimum Data Set mg - milligrams MRSA - Methicillin-Resistant Staphylococcus Aureus (antibiotic resistant infection) NA - Nurse Aide OD - Once a Day PN - Progress Notes PO - Per Orem [by mouth] PROM - Passive Range of Motion PRN - As Needed pt - Patient PT - Physical Therapist q - Every</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

02/07/2017

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

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F 000	Continued From page 1 R - Right RLE - Right Lower Extremity RNA - Restorative Nursing Aide r/o - Rule Out rom - Range of Motion R/T - Related To tx - Treatment W/C - Wheelchair	F 000			
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.  483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.  (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 309		2/13/17	

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F 309	<p>Continued From page 2</p> <p>Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents' pain management needs were anticipated and systematically addressed. This was true for 1 of 5 (#2) sampled residents reviewed for pain management. Resident #2 experienced pain when moved during ADLs and pain impeded her ability to participate in physical therapy or PROM. This deficient practice placed Resident #2 at risk of harm due to decreased quality of life, contractures, and/or further health complications related to decreased mobility. Findings include:</p> <p>Resident #2 was admitted to the facility on 6/2/16 with multiple diagnoses, which included stroke with hemiplegia.</p> <p>Resident #2's Admitting MDS assessment dated 6/2/16, and Quarterly MDS assessment dated 12/19/16, documented Resident #2 was cognitively impaired, usually made herself understood and usually understood others. She required extensive assistance of two people for completing all ADLs. Resident #2's MDS pain assessments documented:</p> <p>*She received PRN pain medications and no non-pharmacological interventions *Her pain was manifested with nonverbal sounds (crying, whining, gasping, moaning, or groaning) and vocal complaints of pain (that hurts, ouch, stop) *She was observed to be in pain 3-4 days in the last 5 days</p> <p>Resident #2's Care Plan, initiated on 6/2/16, documented she was at risk for pain related to</p>	F 309	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Parke View Care &amp; Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <ol style="list-style-type: none"> <li>1. Doctor of resident was contacted and pain management regimen was adjusted</li> <li>2. All residents have potential to be affected. Staff to be interviewed to determine if other residents were exhibiting signs and symptoms of pain during ADLs and cares.</li> <li>3. All resident medication records were updated to have Licensed Nurse to assess pain level each shift and document pain level. Education provided to nursing staff regarding signs and symptoms of pain and what to do if you recognize a resident experiencing pain. Every 10 days to have LN observation of CNA performance of ADL care monitoring for patient signs and symptoms of pain.</li> <li>4. DNS or designee will conduct an audit of pain level responses that will be done weekly for 4 weeks and monthly for 3 months. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that</li> </ol>		

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F 309	<p>Continued From page 3</p> <p>immobility. A goal included, "Will not have an interruption in normal activities due to pain through the review date." Interventions included, "Anticipate need for pain relief and respond immediately to any complaint of pain..." Resident #2's care plan did not include non-pharmacological interventions for pain.</p> <p>Resident #2's admitting Pain Risk Evaluation, dated 6/2/16, identified her as at high risk of pain. The assessment documented Resident #2 had current pain problems, was unable to verbalize the presence of pain, showed pain through nonverbal cues such as grimacing, received 1-2 pain medications, and had no associated symptoms contributing to pain.</p> <p>Resident #2's 9/2/16 quarterly Pain Risk Evaluation included the same information as the 6/2/16 pain evaluation noted above. In addition the 9/2/16 evaluation documented Resident #2 had generalized pain with no specific origin.</p> <p>Resident #2's 11/4/16 quarterly Pain Risk Evaluation also mimicked the 6/2/16 evaluation, and also noted she complained of pain and limitation during physical activities.</p> <p>Nursing Progress Notes documented the following:</p> <p>*10/18/16 at 10:26 am, "...has done well except became upset during shower time. Does not like to be moved or repositioned..."</p> <p>*10/29/16 at 11:53 am, "...tearful before breakfast. Medicated with Tylenol with effective results..."</p>	F 309	the systems are effective.		

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F 309	<p>Continued From page 4</p> <p>*10/29/16 at 22:17 pm, "She did have tearfulness prior to dinner. Tylenol given with effective results. She was c/o knee pain."</p> <p>*10/30/16 at 2:57 pm, "...tearfulness noted before breakfast and after lunch. Res[ident] c/o left leg pain. Tylenol given with effective results."</p> <p>*11/5/16 at 10:16 am, "...did holler out during repositioning and medicated with PRN Tylenol, will continue to monitor."</p> <p>*11/6/16 at 2:04 am, "...medicated with PRN Tylenol for s/s discomfort during repositioning."</p> <p>*11/22/16 at 1:39 am, "Resident tearful. Repositioned in bed. Given Tylenol..."</p> <p>*11/25/16 at 1:55 pm, "...rom Ile not tolerated well even after prn Tylenol given."</p> <p>11/30/16 at 11:33 pm, Resident #2 received a new order for Theragesic topical to be applied on her legs BID PRN for pain.</p> <p>*12/8/16 at 1:33 pm, "...no verbal c/o pain, did yell out during transfer and cried at breakfast table..."</p> <p>*11/8/16, a Fax Communication for Physician documented, "Resident has increased pain with bathing and dressing. May we please try a Duragesic patch or routine pain medications to help with her discomfort? The physician responded with, "Needs an appointment."</p> <p>An 11/10/16 Physician's Visit Communication and</p>	F 309			

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F 309	<p>Continued From page 5</p> <p>Progress Note, documented a nursing concern, "The resident cries out and yells when being repositioned in bed (R upper leg/hip), PRN Tylenol with little relief. Physician orders included: PT eval and treat: Muscle Contracture R thigh...Baclofen 10 mg PO q6 hours PRN [for] pain/muscle spasm."</p> <p>Resident #2's December 2016 recapitulated physician's orders included:</p> <ul style="list-style-type: none"> <li>*Tylenol Extra Strength 500 mg, 2 tablets every 6 hours PRN for pain.</li> <li>*Gabapentin 100 mg orally for nerve pain.</li> <li>*Baclofen 10 mg every 6 hours PRN for pain.</li> <li>*Theragesic Cream 1-15% to be applied topically to legs every 12 hours PRN for pain.</li> </ul> <p>Resident #2's 11/11/16 Physical Therapy Plan of Treatment documented:</p> <ul style="list-style-type: none"> <li>*A short term goal "In order to improve patient quality of life and decrease overall discomfort, she will show signs of decreased pain and muscle tone in RLE with palpation /massage."</li> <li>*A Long Term Goal, "In order to improve patient quality of life and decrease overall discomfort, she will show signs of decreased pain and muscle tone in RLE at all times such as when performing functional tasks in bed and during showers with nursing..."</li> <li>*Treatment may include hot or cold packs therapy, diathermy treatment..., therapeutic exercises, massage therapy, manual therapy and therapeutic activities."</li> </ul>	F 309			

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F 309	<p>Continued From page 6</p> <p>A Physical Therapy Treatment Encounter documented Resident #2 had physical therapy on 11/10/16, 11/11/16, 11/13/16, 11/16/16, 11/18/16, 11/19/16, 11/21/16, 11/27/16, 11/29/16, 11/30/16, 12/3/16, 12/6/16 and 12/9 16. During 7 of the 13 days she received physical therapy (53%) it was documented she experienced pain during the therapy session. On the therapy days Resident #2 had pain she received Gabapentin 100 mg orally and Baclofen 10 mg PRN between 5:00 am and 9:00 am and between 5:00 pm and 6:00 pm, and two 500 mg tablets of Tylenol PRN between 5:00 am and 12:00 noon. There was no documentation Resident #2 was given PRN medications prior to receiving physical therapy.</p> <p>A 12/9/16 Physical Therapy Discharge Summary documented, "Unfortunately patient progress has been very limited as her R hip and thigh pain continues. She has significant pain on her R hip with any movement such as flex[ion], add[uction] and IR [internal rotation] and has not shown significant improvement with skilled therapy and this point she will be d/c d/t lack of progress...Nursing staff will be educated in performing RLE ROM activities at pt tolerates."</p> <p>On 1/10/16 at 7:57 am, Resident #2 was observed being transferred from her wheelchair to her bed via hooyer lift. Before the transfer, Resident #2 was quiet, at times she was seen smiling at CNA #5 and RNA #1, as well as, the surveyor, but as soon as the hooyer was lifted Resident #2 started to cry out loud. She was still crying as she was being position on her bed. CNA #5 and RNA #1 stopped for a while and waited for Resident #2 to calm. When Resident #2 was lying flat on the bed, CNA #5, assisted by</p>	F 309			

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F 309	<p>Continued From page 7</p> <p>RNA #1, turned Resident #2 to her right side. Resident #2 started to cry again. She was crying throughout the process as her incontinent brief was removed and a new one placed on her. CNA #5 and RNA #1 tried to comfort Resident #2 by talking to her, but to no avail. Resident #2 was observed to stop crying only when her right leg was not being moved. CNA #5 then applied ted hose to Resident #2's left leg with no problem but when she tried to put the ted hose on her right leg, Resident #2 cried out loud. When CNA #5 asked Resident #2 if she could apply the ted hose on her right leg, Resident #2 shook her head, indicating "no". CNA #5 called LN #1 and informed the LN that she could not apply the ted hose on Resident #2's right leg as she refused because of pain. LN #1 entered the room and applied Theragesic cream to Resident #2's right leg. CNA #5 and RNA #1 said Resident #2 always cried when her right leg was being moved, and sometimes she cried out loud when being changed or repositioned, but once positioned on her wheelchair or bed, she was fine.</p> <p>On 1/10/17 at 8:32 am, LN #1 said Resident #2 was on PRN pain medication but not on routine pain medications, and was given her pain medications when she complained of pain. When asked, LN #1 said she did not know if Resident #2 always cried out in pain when moved. LN #1 said she did not always work on the hall where Resident #2 resided. When asked, LN #1 said she was not informed of Resident #2's pain by the previous LN on duty.</p> <p>On 1/12/17 at 2:30 pm, Resident #2 was observed performing PROM exercises with RNA</p>	F 309			

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F 309	Continued From page 8 #2. Resident #2 was able to do her PROM on her right arm, but was not able to tolerate the PROM exercise for her right leg. Resident #2 was observed to grimace as RNA #2 slowly moved her right leg. When RNA #2 tried to flex Resident #2's right knee, Resident #2 was about to cry. RNA #2 then stopped the session. RNA #2 said Resident #2 could finish her PROM exercises about half the time and half the time she could not due to pain. RNA #2 said if the RNA session was not completed she would write it on a sticky note and request that the LN medicate Resident #2. RNA #2 said she could sometimes come back and resume the PROM, and other times she could not. Resident #2's Nurse's Notes documented only one incident of her not being able tolerate PROM after Tylenol was given.  On 1/12/17 at 11:30 am, the PT said Resident #2's treatment was discontinued because of her pain and her inability to tolerate the exercises. The PT also said Resident #2 did not show a decreased pain level during physical therapy. The PT said there was no fixed schedule for Resident #2's physical therapy, sometimes it was in the afternoon and sometimes in the morning. The PT said he did not know for sure, but Resident #2's pain could be due to muscle spasms as a result of her stroke.  Resident #2 experienced signs and symptoms of pain when being moved during ADLs and during PT/PROM exercises. Resident #2's care plan which called for staff to anticipate her need for pain medications, was not followed. The facility failed to proactively address Resident #2's pain management needs.	F 309			
F 328	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE	F 328		2/13/17	

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F 328 SS=D	Continued From page 9 FOR SPECIAL NEEDS  (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:  (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and  (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments  (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.  (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.  (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.	F 328			

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F 328	<p>Continued From page 10</p> <p>(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure oxygen therapy was administered consistent with physician orders. This was true for 1 of 1 sampled resident (#6) reviewed for use of supplemental oxygen. The deficient practice created the potential for harm if the resident received more, or less, oxygen than required to maintain homeostasis. Findings include:  Resident #6 was admitted to the facility on 10/19/16, with diagnoses that included peripheral vascular disease and hypertension.  Physician orders, dated 11/8/16, directed staff to provide Resident #6 with oxygen at the rate of 2 liters per minute [2 LPM] via nasal cannula to maintain blood-oxygen saturation levels at 90-percent or greater.</p>	F 328	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Parke View Care &amp; Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p> <ol style="list-style-type: none"> <li>1. Resident's oxygen setting was adjusted to proper liter flow</li> <li>2. All residents with current oxygen orders have the potential to be affected.</li> </ol>		

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F 328	Continued From page 11  Resident #6's current Oxygen Therapy Care Plan, initiated 10/19/16, documented, "Oxygen Settings: Supplemental oxygen at 2 LPM via cannula continuously."  Resident #6 was observed in his room receiving oxygen via a nasal cannula at 4 LPM on 1/10/17 at 8:50 am, 9:25 am, and 10:20 am, and on 1/11/17 at 9:08 am and 3:40 pm with the DON. At the time of the observation, the DON stated, "It [Resident #6's oxygen flow] should be two liters per minute."	F 328	All residents with current oxygen orders were observed for proper liter flow. 3. Education provided to licensed nurses to verify oxygen liter flow matches current orders. Educated nursing staff that non-licensed staff cannot change liter flow. 4. DNS or designee will audit that oxygen orders match observed flow rate of oxygen weekly for 4 weeks and monthly for 3 months. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.		
F 368 SS=E	483.60(f)(1)-(3) FREQUENCY OF MEALS/SNACKS AT BEDTIME  (f) Frequency of Meals  (f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.  (f)(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.  (f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.	F 368		2/13/17	

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F 368	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to offer bed time snacks to 3 of 15 sampled residents (#3, #5, and #9) and to 8 of 9 residents from the resident group interview. Findings include:</p> <p>On 1/10/17 at 11:00 a.m. a resident group interview was held; 8 of 9 residents in the meeting confirmed they were not offered or served bed time snacks every night.</p> <p>On 1/10/17 at about 4:15 p.m., the dietary manager (DM) stated the dietary department was responsible for stocking the refrigerators on the units every other morning with a variety of bed time snacks. The DM stated the snacks were available for residents; residents could help themselves and/or staff were to offer snacks to the residents.</p> <p>On 1/11/17 at 9:25 a.m. and 4:00 p.m., during two separate confidential interviews with sampled residents, these two residents stated they were not offered or served bed time snacks. On 1/13/17 at 10:15 a.m., one of the sampled residents was interviewed a second time and reported being offered and receiving a bed time snack the night before, for the first time in two years. The resident stated it was about 8:00 p.m. when the staff offered/served the snack. The resident stated it was very nice receiving the snack and hoped the facility would continue with the routine. However, the resident stated the CNA mentioned to her they were too short staffed to always pass snacks.</p>	F 368	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Parke View Care &amp; Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p> <ol style="list-style-type: none"> <li>1. All residents were offered HS snacks.</li> <li>2. All residents that are not NPO have the potential to be affected by this practice. Alert residents interviewed to find out if they are receiving HS snacks.</li> <li>3. Education provided to nursing staff to offer all non-NPO residents HS snacks. Dietary department sending snacks out each evening to hand out.</li> <li>4. Dietary Manager or designee to interview alert residents from each hall if they are receiving HS snacks weekly for 4 weeks and monthly for 3 months. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.</li> </ol>		

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PRINTED: 02/10/2017  
FORM APPROVED  
OMB NO. 0938-0391

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F 368	<p>Continued From page 13</p> <p>On 1/11/17 at approximately 4:05 p.m., the nutrition refrigerator on the East Park Unit contained 11 small cups of yogurt. On 1/11/17 at about 4:10 p.m., the nutrition refrigerator on the North Park Unit contained 8 small cups of yogurt. The director of nursing stated on 1/13/17 at 10:42 a.m. there were 20 residents residing on East unit and 30 residents residing on North unit (who received food by mouth versus by a feeding tube). The refrigerators did not contain a sufficient amount of snacks for all residents.</p> <p>On 1/12/17 at 8:20 a.m., the DM stated when she stocked the East Park Unit with snacks during the morning on this date, no yogurt cups were left from the night before and two cups were left from the night before on the North Park Unit.</p> <p>On 1/12/17 at 3:50 p.m., certified nurse aide (CNA)1 and CNA 2 stated dietary staff stocked the refrigerators in the mornings and residents could help themselves to the snacks. They both stated bed time snacks were supposed to be offered to all residents at 8:30 p.m., with staff going room to room unless the residents were already in bed asleep.</p> <p>On 1/12/17 at 3:57 p.m., CNA 3 stated bed time snacks were offered to all residents at 8:00 p.m. She stated she went to each room unless the residents were asleep. The residents who were asleep were asked if they wanted a bed time snack when they got up to toilet later in the shift.</p> <p>Review of the electronic documentation for residents' snacks from 1/1/17 to 1/11/17, reflected resident 3 and resident 5 were not</p>	F 368			

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F 368	Continued From page 14 offered snacks 3 times (1/5/17, 1/6/17, 1/10/17). Resident 9 was not offered a snack 4 times (1/3/17, 1/5/17, 1/6/17, 1/10/17) during the same 11-day period.	F 368			
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS  (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:  (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 (facility assessment implementation is Phase 2);  (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 communicable disease or infections should be reported;  (iii) Standard and transmission-based precautions to be followed to prevent spread of	F 441		2/13/17	

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F 441	<p>Continued From page 15 infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>(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, staff interview, and facility policy review, it was determined the facility failed to ensure staff observed contact precautions to avoid the spread of infection. This was true for 1</p>	F 441	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Parke View Care &amp; Rehabilitation Center does</p>		

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F 441	<p>Continued From page 16 of 15 sampled residents (#6) reviewed for infection control practices and had the potential to spread infectious organisms to other residents in the facility. Findings include:</p> <p>Resident #6 was admitted to the facility on 10/19/16, and readmitted on 11/19/16, with diagnoses that included peripheral vascular disease and bilateral above-the-knee [AKA] amputations of the lower extremities.</p> <p>Nurse Progress Notes documented Resident #5 was discharged from the facility 11/14/16 for surgery and readmitted to the facility on 11/19/16 for "post op[erative] care after bilateral AKA." Nurse Progress Notes also documented the following:</p> <p>* 12/3/16 - "[Resident #6] continues with PO ABT [oral antibiotic] for recent surgery to bi-lat[eral] legs, AKA, ...scant amounts of drainage from sites..."</p> <p>* 12/4/16 - "...had bi-lat AKA with incisions to both stumps. Scant amount of light yellow drainage noted."</p> <p>* 12/5/16 - "Also informed [physician] of pt [patient] bladder incontinence and spilling of urine from urinal...with bilateral AKA incisional dressings getting wet with urine and concern with infection to incisional areas."</p> <p>* 12/7/16 - "L[eft] stump is very red and painful, seeing the surgeon today."</p> <p>* 12/8/16 - "...surgeon removed some of the sutures and during removal on left stump his suture removal instrument went into the incision and a large amount of fluid was expelled..."</p> <p>12/10/16 - "Res[ident] continues on antibiotics for diagnosis of infection at surgical sites. Res has a</p>	F 441	<p>not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p> <ol style="list-style-type: none"> <li>1. Identified staff members educated on universal precautions</li> <li>2. All residents can be affected by this practice. Hand washing observation done for nursing staff.</li> <li>3. Education provided to nursing staff regarding universal precautions, hand washing, and infection control practices.</li> <li>4. DNS or designee will perform hand washing observation audits and contact precaution observation audits for nursing staff weekly for 4 weeks and monthly for 3 months. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.</li> </ol>		

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F 441	<p>Continued From page 17</p> <p>small amount of yellow colored drainage from the left incision...Incision on the left side is red..."</p> <p>* 12/11/16 - "Res continues on abx for infection of his surgical incisions. Res has had a moderate amount of yellow drainage from the incision on the left stump."</p> <p>* 12/18/16 - "Continues with contact isolation d/t MRSA." This was the first documentation of MRSA and/or "contact isolation" in Resident #4's clinical record.</p> <p>* 12/30/16 - "New orders for Zyvox [antibiotic] for another 10 days for MRSA drainage to left stump incision..."</p> <p>* 1/5/17 at 10:24 am - "...continues with PO ABT for MRSA L[eft] stump..."</p> <p>* 1/5/17 at 2:00 pm - "...incision to stump is infected with MRSA..."</p> <p>* 1/5/17 at 3:35 pm - "...new order to culture L[eft] stump to r/o MRSA..."</p> <p>Physician Orders for Resident #6 documented the following:</p> <p>* 12/8/16 - Augmentin [antibiotic] 500 mg BID "for wound infection..."</p> <p>* 12/14/16 - Zyvox 600 mg BID "for [unspecified AKA] incision drainage..."</p> <p>* 12/30/16 - Zyvox 600 mg BID "for MRSA to left stump incision..."</p> <p>* 1/5/17 - Culture of "left stump" for MRSA</p> <p>Resident #6's Skin Integrity/Surgical Wounds Care Plan, initiated 11/23/16 and in effect during the facility's federal recertification survey of 1/9/17 through 1/13/17, did not include documentation related to MRSA or contact precautions.</p> <p>On 1/9/17 at 2:55 pm, and throughout the</p>	F 441			

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F 441	<p>Continued From page 18</p> <p>recertification survey, Resident #6's room was observed with an isolation cart in the hallway outside the door. An unidentified CNA at this time stated Resident #6 was "under contact precautions for MRSA in his left stump."</p> <p>On 1/10/17 at 12:20 pm, two staff members wearing protective gowns and gloves were observed transferring Resident #6 to a wheelchair using a Hoyer mechanical lift.</p> <p>On 1/11/17 at 9:08 am, RNA #2 and CNA #4 were observed using a transfer sheet to reposition Resident #6 on his right side in bed. Neither staff member was wearing a protective gown or gloves. Following the repositioning, RNA #2 placed the nasal cannula on Resident #6's face, walked to his hallway door, turned around, and returned to the bedroom sink, where she washed her hands before leaving Resident #6's room. CNA #4, who had walked into Resident #6's bathroom, emerged with gloves on her hands and holding Resident #6's urinal. CNA #4 then washed her hands and exited Resident #6's room.</p> <p>On 1/11/17 at 9:15 am, RNA #2 stated, "He is," when asked whether Resident #6 was on contact precautions. When asked whether she washed her hands prior to placing the nasal cannula into place on Resident #6's face, RNA #2 stated, "No I did not."</p> <p>On 1/11/17 at 9:30 am, CNA #4, when asked whether contact precautions were still in effect for Resident #6, stated, "I don't think they've cleared him yet, but I thought we don't have to gown up because it's [MRSA] in his legs." When asked</p>	F 441			

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135068</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/13/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARKE VIEW REHABILITATION &amp; CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2303 PARKE AVENUE BURLEY, ID 83318</b>		
(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 441	Continued From page 19 about not wearing gloves while handling the transfer sheet Resident #6 layed on while in bed to reposition him, CNA #4 stated, "It didn't occur to me to wear gloves."  On 1/11/17 at 10:23 am, the ADON stated the 1/5/17 cultures taken from Resident #6's LLE surgical wound were negative for MRSA, however, those laboratory results had not yet been shared with staff.  The facility's Infection Control Policy/Procedure, revised September 2007, documented staff was not required to wear gloves with MRSA infected residents unless "handling drainage/secretions or soiled items that may contain MRSA organisms. Wear gloves only if soiling with drainage or secretions is likely."  A MRSA - Management of Recurrent Skin and Soft Tissue Infection policy contained in the facility's current Infection Control Policy and Procedure Manual and dated August 2011, documented, "Utilize standard precautions at all times for all resident care. CDC recommends contact precautions when the facility...deems MRSA to be of special clinical and epidemiologic significance."	F 441			
F 494 SS=E	483.35(d)(1)(2) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY  (d)(1) General rule A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless--  (i) That individual is competent to provide nursing and nursing related services; and	F 494		2/13/17	



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

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F 494	Continued From page 21 On 1/13/17 at 11:55 am, the Administrator said NA #1 was initially hired on 7/28/16, but started working on 8/5/16, and was terminated on 11/29/16. The Administrator said NA #1 took the state competency test three times but was not able to pass the test due to a language barrier. When NA #1 re-enrolled in the Certified Nursing Assistant program, the facility hired her again on 12/6/16. The Administrator asked if NA #1 would receive another 4 month grace period when she re-enrolled, and was informed by the surveyor that the four month period is cumulative, and does not start over upon re-enrollment.	F 494	time worked since hire date. 3. Education provided to hiring manager regarding regulation. Alert placed on calendar to be notified of all NAs approaching timeframe at 100 days. 4. All Nurse Aide's time worked will be audited weekly for 4 weeks and monthly for 3 months. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.		



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

TAMARA PRISOCK—ADMINISTRATOR  
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April 24, 2017

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

Provider #: 135068

Dear Mr. Lewis, Jr.:

On **January 13, 2017**, an unannounced on-site complaint survey was conducted at Parke View Rehabilitation & Care Center. This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted from January 9, 2017 to January 13, 2017.

The following observations were conducted:

During the initial tour and throughout the survey, observations of the residents were made with regard to their appearances and grooming; nursing cares provided to the identified resident and four other residents, including a resident with traumatic brain injury who was bed bound; and catheters and catheter care for two residents and that of the identified resident. Staff and resident interactions were also observed from January 9, 2017 through January 13, 2017.

The following documents were reviewed: The entire clinical record of the identified resident and thirteen other residents; the hospital record of the identified resident; and the facility's Incident and Accident reports and Grievances from September 2016 to December 2016,

The following interviews were completed: The identified resident and the identified resident's family member, Administrator, Director of Nursing, two Licensed Nurses, three Certified Nursing Assistants and Licensed Social Worker. Nine residents in the Group Interview meeting were interviewed for Quality of Care concerns.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007389**

ALLEGATION #1:

The resident was filthy from not being bathed for an undetermined amount of time; his/her hair was w matted it could not be combed or brushed.

FINDINGS:

The identified resident's clinical record documented the resident had baths, shower, or sponge baths two times a week. The identified resident and other residents were observed for grooming and appearances. All were appropriately dressed and groomed. Nine residents who attended the Group Interview did not express any concerns with regards to bathing.

Based on observation, record review and interviews, this allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Multiple bruises were discovered on the resident's body.

FINDINGS:

The identified resident was asked if she could recall whether any staff had hurt her in the past. The resident said none of the staff had hurt her. The Administrator said, when asked by facility personnel, the resident stated she easily bruises if she bumped into something. The Administrator said the identified resident was very vocal, could express herself without difficulty, and was not easily intimidated. Nine residents in the Group Interview did not voice any concern involving staff treatment of residents.

Based on record review and interview, this allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

A pressure ulcer developed on the resident's buttocks from laying in feces and urine.

FINDINGS:

Corwin Lewis, Jr., Administrator  
April 24, 2017  
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The identified resident's Skin Assessment record from August 6, 2016 to October 6, 2016 did not document any pressure ulcer on any part of her body. The DON said the resident had no skin issues when she left for the hospital on October 6, 2016. The identified resident's October 6, 2016 hospital record documented her skin had no rashes or lesions. An October 7, 2016 hospital record documented the resident had skin breakdown on her buttocks.

Based on record review and interview, this allegation could not be substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #4:**

The resident's catheter had a foul odor, the catheter strap was visibly soiled with feces/urine, and there was sediment in the catheter tube, which blocked and inhibiting urine from draining into the catheter bag.

**FINDINGS:**

The identified resident's August 2016 to October 2016 TAR documented her urinary catheter was changed every twelfth day of the month. Two other residents with urinary catheters expressed no concerns with their cares. The identified resident's October 6, 2016 hospital record did not document that her urinary catheter strap was soiled with feces or urine or had a foul odor.

Based on record review and interviews, this 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.

Sincerely,

A handwritten signature in black ink that reads "D. I. Scott". The signature is written in a cursive style with a large initial "D" and "S".

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

Corwin Lewis, Jr., Administrator  
April 24, 2017  
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DS/lj