



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

March 31, 2017

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

Provider #: 135098

Dear Mr. Barnes:

On **March 16, 2017**, a survey was conducted at Valley View Nursing & Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes 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 **April 19, 2017**. Failure to submit an acceptable PoC by **April 19, 2017**, may result in the imposition of penalties by May 3, 2107.

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 **April 20, 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 **June 14, 2017**. A change in the seriousness of the deficiencies on **April 30, 2017**, may result in a change

Randal Barnes, Administrator
March 31, 2017
Page 3

in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 14, 2017** includes the following:

Denial of payment for new admissions effective **June 14, 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 **September 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 **June 14, 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:

Randal Barnes, Administrator
March 31, 2017
Page 4

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

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

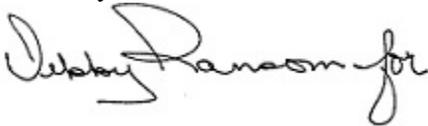
- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **April 19, 2017**. If your request for informal dispute resolution is received after **April 19, 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,



[Nina Sanderson, LSW](#), Supervisor
Long Term Care

[ns/dr](#)
Enclosures

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

PRINTED: 04/14/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/16/2017
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1140 NORTH ALLUMBAUGH STREET BOISE, ID 83704		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during a complaint survey conducted at the facility from March 15, 2017 to March 16, 2017. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Edith Cecil, RN Survey Abbreviations: ADON = Assistant Director of Nursing F = Fahrenheit hr = hour IV = Intravenous LN = Licensed Nurse MAR = Medication Administration Record NP = Nurse Practitioner	F 000			
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 157		4/20/17	

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

TITLE

(X6) DATE

Electronically Signed

04/07/2017

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 157	<p>Continued From page 1 clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on review of facility policies, record review, and staff interview, it was determined the facility failed to ensure the physician was notified when a resident did not receive two doses of IV [intravenous] antibiotic therapy. This was true for</p>	F 157	<p>F157</p> <p>This requirement was not met as evidenced by the determination that the</p>		

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F 157	<p>Continued From page 2</p> <p>1 of 4 sampled residents (Resident #4.) Resident #4 was placed at potential for harm when her physician was not notified of the missed doses of antibiotics. Findings include:</p> <p>Resident #4 was admitted to the facility on 2/7/17 with diagnoses of a septic joint following a revision of a distal femur [thighbone just above the knee] replacement and infection of the total right knee replacement.</p> <p>Physician admission/transfer orders from the hospital included the administration of Ceftriaxone 2 grams IV daily, an antibiotic for the treatment of the septic joint. The hospital provided the facility with Resident #4's MAR [Medication Administration Record] which documented Ceftriaxone 2 grams IV every 24 hours had been last administered on 2/6/17 at 9:00 pm.</p> <p>Resident #4's MAR, dated 2/7/17, for the administration of Ceftriaxone 2 grams was blank. Progress notes reviewed for 2/7/17 did not include documentation the physician was notified that the antibiotic therapy not administered.</p> <p>On 2/8/17 at 3:36 pm, for Ceftriaxone 2 grams, LN #1 documented a number 5. The chart code/follow up code for the number 5 indicated Hold/See Progress Notes.</p> <p>Progress Note, dated 2/8/17 at 3:36 pm, showed a medication administrative note that documented the medication was not available and would be administer when it arrived. The documentation did not indicate the physician had been notified.</p>	F 157	<p>facility failed to ensure the physician was notified when a resident did not receive two doses of IV antibiotic therapy</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident #4 discharged prior to the survey, no correction possible.</p> <p>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>All residents receiving medication have the potential for being affected by this deficit.</p> <p>RN and LPN staff will be in-serviced week of 4/10/2017 about the need to administer medications to match the physicians order with accurate documentation of administration on the eMAR; to the Medication Error/ Omissions procedure; and the need to notify the physician promptly in the event of a medication omission or error.</p> <p>The facility Medication Error Report has been updated to include omissions of medications as an error.</p> <p>3. What measures will be put in place or what systemic change you will make to</p>		

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F 157	<p>Continued From page 3</p> <p>A facility policy titled Medication Errors/Omissions, dated 3/16 and revised 8/16, stated a medication error report would be completed for omitted medication. The policy directed licensed staff to notify the physician of medication errors and omissions and if the medication had the potential to cause serious harm, the physician would be immediately contacted for further directions.</p> <p>On 3/15/17 at 8:00 am, facility Medication Error reports from 1/1/17 through 3/15/17 were reviewed. There were no medication error reports completed for Resident #4.</p> <p>On 3/16/17 at 9:00 am, the ADON stated that if a medication error is reported, it would be expected that the physician would be notified. The ADON stated the medication error report directed the notification of the physician. The ADON reviewed Resident #4's progress notes for documentation of physician notification of 2 doses of antibiotic therapy omitted and stated she did not see documentation of physician notification of the 2 missed doses.</p>	F 157	<p>ensure that the deficient practice does not recur.</p> <p>Procedures for Medication Errors and Notification of Change were reviewed and revised as appropriate. Medication Error Report has been changed to also reflect omission of medication.</p> <p>In-Service education will be completed the week of 4/10/17 with the RN and LPN staff regarding medication administration per physician orders, when and how to complete the Medication Error/Omission report to include notification of the physician.</p> <p>In-service education will be completed the week of 4/10/17 with the RN and LPN staff regarding the notification of changes to ensure that the resident, the residents physician and, consistent with his/her authority the residents representative is notified per facility procedure.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</p> <p>The DON or designee will randomly audit 20 resident records to ensure that medications and treatments have been administered per the physician's order if an error/omission was identified DON or</p>		

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F 157	Continued From page 4	F 157	designee will audit to ensure facility procedure for error/omission was followed. This audit will occur weekly x 4 weeks then monthly x 2 months and then as needed once the Quality Assurance Committee deems compliance is being maintained. The results of documentation audits will be taken to the monthly QAPI meeting for review and adjustments made as indicated.		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of pharmacy manifests, and staff interview, it was determined the facility failed to ensure 1 of 4 residents sampled (Resident #4) received medications as ordered by the physician. This deficient practice had the potential for harm to Resident #4 for worsening of the infection of a total knee replacement joint. Findings include: Resident #4 was admitted to the facility on 2/7/17 with diagnosis of septic joint following a revision	F 281	5. Date Corrective action will be completed: 4/20/2017 F281 This requirement was not met as evidenced by the determination that the facility failed to Ensure 1 of 4 residents sampled received medications as ordered by the physician. 1. What corrective action(s) will be	4/20/17	

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F 281	<p>Continued From page 5 of distal femur [high bone right above the knee joint] replacement and infection of the total right knee replacement.</p> <p>Resident #4's physician admission/transfer orders from the hospital included the administration of Ceftriaxone 2 grams IV daily, an antibiotic for the treatment of the septic joint. The hospital provided the facility with Resident #4's MAR [Medication Administration Record] which documented Ceftriaxone 2 grams IV every 24 hours had been last administered on 2/6/17 at 9:00 pm. The admission orders included direction for Resident #4 to make an appointment with the Infectious Disease physician for 2 weeks from admission to facility. Resident #4 arrived at the facility at 4:20 pm.</p> <p>On 2/7/17, the MAR for the administration of Ceftriaxone 2 grams, was blank which indicated the IV antibiotic was not administered. A pharmacy delivery manifest, dated 2/7/17 at 7:29 pm, signed by LN #2, documented 4 doses of Ceftriaxone 2 grams were delivered to the facility for Resident #4. LN #2's initials were noted throughout the MAR on 2/7/17 which included care to the IV catheter but was not noted on the IV antibiotic administration.</p> <p>On 2/8/17 at 3:36 pm, on the MAR for the administration of Ceftriaxone 2 grams, LN #1 documented the number 5. The chart code/follow up code for the number 5 indicated Hold/See Progress Notes. A corresponding progress note, dated 2/8/17 at 3:36 pm, LN #1 documented the medication was not available and would be administered when it arrived. The pharmacy delivery manifest dated 2/8/17 at 6:24 pm,</p>	F 281	<p>accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident #4 discharged prior to the survey, no correction possible.</p> <p>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>All residents receiving medication have the potential for being affected by this deficit.</p> <p>RN and LPN staff will be in-serviced week of 4/10/17 about the need to administer medications to match the physicians order with accurate documentation of administration on the eMAR, and what to do if a medication is unavailable for administration to include access to the Omnicell (back up supply) or special delivery from pharmacy.</p> <p>In-service education to RN and LPN staff and HIM staff to also to include the need to identify the time the last dose of medication(s) was (were) received in the prior setting for newly admitting residents, if possible. This can be done using facility to facility nurse report and may be present on transfer documents. If unable to identify prior dose time, will follow</p>		

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F 281	<p>Continued From page 6</p> <p>unsigned by facility staff, documented 3 doses of Ceftriaxone was delivered to the facility for Resident #4.</p> <p>The NP [Nurse Practitioner] visit note dated 2/8/17, documented Resident #4 was breathing well, she was eating well, her blood pressure was 143/77, and her temperature was 97 degrees F. The NP note documented Resident #4's main concern was pain management and she was in no apparent distress.</p> <p>On 2/ 9/17 the MAR documented Ceftriaxone 2 grams was administered at 2:36 pm.</p> <p>On 2/10/17 the MAR documented Ceftriaxone 2 grams medication was administered at 1:58 pm. The pharmacy delivery manifest, dated 2/10/17 at 3:48 pm, signed by LN #3; documented 4 doses of Ceftriaxone were delivered to the facility for Resident #4.</p> <p>An NP visit note, dated 2/10/17, documented a decline in Resident #4's condition. The NP documented Resident #4 developed a fever on the evening of 2/9/17, had increased pain, and redness to her right lower extremity, and decreased blood pressure. The NP note documented Resident #4's blood pressure was 89/59, her respirations were 24 per minute, her temperature was 100.3 degrees F, and she was requiring some oxygen supplementation. The NP note described Resident #4 as very pale and shivering with multiple blankets on top of her. The note documented the pain to Resident #4's right lower extremity had increased significantly and the heat and redness to the right leg above the knee also increased significantly.</p>	F 281	<p>Valley View Medication Administration procedure.</p> <p>3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.</p> <p>Procedures for Medication Administration and Medication Orders and Medication/Prescription Ordering and Re-Ordering was reviewed and revised as appropriate.</p> <p>RN and LPN staff will be in-serviced week of 4/10/17 about the need to administer medications to match the physicians order with accurate documentation of administration on the eMAR, and what to do if a medication is unavailable for administration to include access to the Omnicell (back up supply) or special delivery from pharmacy.</p> <p>In-service education to RN and LPN staff and HIM staff to also include the need to identify the time the last dose of medication(s) was (were) received in the prior setting for newly admitting residents, if possible. This can be done using facility to facility nurse report and may be present on transfer documents. If unable to identify prior dose time, will follow Valley View Medication Administration procedure.</p>		

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F 281	<p>Continued From page 7</p> <p>The NP documented Resident #4's treatment of osteomyelitis with IV antibiotics. The NP was concerned that the antibiotics were not treating her infection and Resident #4 appeared to becoming septic. The NP documented Resident #4 would be transferred to a hospital for work up and treatment for diagnosis of worsening wound infection, osteomyelitis, unstable pain, sepsis, and blood pressure control.</p> <p>On 3/15/17 at 2:45 pm, LN # 1 stated she was unable to find Resident #4's IV antibiotic for administration on 2/8/17. LN #1 stated when it was not found in the medication room or the medication cart, the unit manager directed her to call the pharmacy to get the antibiotic delivered. LN #1 reviewed the pharmacy delivery slip, dated 2/7/17 at 7:29 pm, which documented 4 doses of ceftriaxone were delivered for Resident #4, and identified LN #2's signature on the delivery slip. LN #1 stated she could not find the antibiotic on 2/8/17.</p> <p>On 3/15/17 at 3:30 pm, the ADON [Assistant Director of Nursing] stated the expectation is for the licensed nurses to do whatever they can to get the medications, especially antibiotics. The ADON stated the licensed nurses could access the Omnicell a cabinet that stores a variety of medications for the general population] to ensure a resident's medication needs are met. The ADON provided a list of medications available in the Omnicell, updated on 2/9/17. Ceftriaxone 1 gram vials were on the list.</p> <p>On 3/15/17 at 4:30 pm, a phone call placed to LN #2. LN #2 was not available and a message</p>	F 281	<p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</p> <p>The DON or designee will randomly audit 20 resident records to ensure that medications and treatments have been administered per the physician's order. This audit will occur weekly x 4 weeks then monthly x 2 months and then as needed once the Quality Assurance Committee deems compliance is being maintained. The results of documentation audits will be taken to the monthly QAPI meeting for review and adjustments made as indicated.</p> <p>5. Date Corrective action will be completed: 4/20/2017</p>		

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/16/2017
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1140 NORTH ALLUMBAUGH STREET BOISE, ID 83704		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 8 could not be left to request a return call.</p> <p>On 3/16/17 at 9:00 am, the ADON stated the medical records staff entered resident orders in the electronic medical record system and a licensed nurse then reviewed the orders. The electronic Medication Administration Record utilized by the facility directed licensed nurses to provide physician ordered medications and the time each medication was to be given. The entry for Ceftriaxone 2 grams IV was documented "24hr" in the hour column. The ADON stated when an antibiotic is ordered for a new admission, the transfer orders should be reviewed to determine the time of the last dose received prior to the transfer and identify and schedule the time the next dose of antibiotic is to be administered. The ADON stated the start time for Resident #4's administration of Ceftriaxone was not changed to reflect the correct time for the next dose [which was 2/7/17 at 9:00 pm].</p> <p>The ADON stated an audit is completed within 72 hours for new admissions. The ADON agreed 72 hours had elapsed between the last dose of antibiotics Resident #4 received at the hospital and the first dose administered after admission to the facility. When asked if this could compromise Resident #4, the ADON stated it very possibly could. The ADON stated it could worsen the infection.</p> <p>The facility failed to administer two doses of IV antibiotic therapy to Resident #4 as ordered.</p>	F 281			



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

June 6, 2017

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

Provider #: 135098

Dear Mr. Barnes:

On **March 16, 2017**, an unannounced on-site complaint survey was conducted at Valley View Nursing & Rehabilitation. This complaint was investigated on March 15 and March 16, 2017. During the complaint survey, four residents were reviewed, including the identified resident, who no longer resided in the facility.

The identified resident's clinical record, and those of three other residents, were reviewed and included physician orders, medication administration records, the provision of treatments, care plans, Social Services, physician progress notes, nursing notes, and pain monitors. Facility policy and procedures were reviewed for Notification of Change, delivery and receipt of medications, and medication errors and omissions.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007472

ALLEGATION #1:

The Reporting Party stated the facility failed to collect the identified resident from a hospital upon her discharge to the facility.

Randal Barnes, Administrator
June 6, 2017
Page 2 of 4

FINDINGS:

The Marketing and Admissions Director for the facility provided a discharge checklist for the identified resident and stated admission was initially planned for a Monday, however the hospital physician postponed to keep the identified resident another 24 hours. A Discharge Summary, dated February 7, 2017, documented the identified resident "desired discharge on postoperative day 10." Medication orders for transfer were dated February 7, 2017. The identified resident was discharged on February 7, 2017. The facility provided transportation to pick the identified resident up at 3:45 pm on February 7, 2017, and the resident arrived at the facility at 4:20 pm.

No deficiencies were cited for this allegation.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The Reporting Party stated the identified resident was in "horrible" pain when she arrived at the facility at 7:30 pm. The staff informed her the pain medications had not arrived from the pharmacy. The Reporting Party stated the identified resident could have received 3 doses of pain medication and the facility told the resident that she could not have another dose until the next dose was indicated. The Reporting Party stated the the Resident's medications arrived at the facility at midnight.

FINDINGS:

The identified resident arrived in the facility at approximately 4:20 pm on February 7, 2017. Physician Orders to manage the identified resident's pain included Tramadol 50 mg, two tablets every 6 hours as needed for mild pain and Oxycodone 5 mg every 4 hours as needed for mild to moderate pain unrelieved by Tramadol. The Medication Administration Record and the Nursing Notes documented Oxycodone 5 mg was given to the resident at 8:17 pm and was documented as effective at 10:18 pm. Tramadol 100 mg was given to the resident at 11:28 pm. Oxycodone 5 mg was given at 12:30 am and was documented as effective at 1:48 am. No deficiencies were cited for this allegation. On February 8, 2017 at 1:49 am, the identified resident requested and received Tramadol 100 mg. At 8:10 am, the identified resident requested and received Oxycodone 5 mg.

On March 15, 2017 and March 16, 2017, three sampled residents in the facility were reviewed for pain management and interviewed about the effectiveness of the their pain management. Licensed Nurses were interviewed regarding pain management. A pain assessment was

Randal Barnes, Administrator
June 6, 2017
Page 3 of 4

completed on admission, and a pain monitor was initiated for every resident. An admission assessment documented the identified resident as alert, oriented, and able to make her needs known. No concerns were identified. Based on observation, record review, and resident and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The Reporting Party said IV antibiotics did not arrive at the facility at midnight of February 8, 2017 with the rest of the identified resident's medications and the identified resident did not receive IV antibiotics at any point on February 8, 2017.

FINDINGS:

This allegations was substantiated at F281. Please see federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION# 4:

The Reporting Party stated the facility did not call to inform her the identified resident was discharging to the hospital.

FINDINGS:

The identified resident's clinical record was reviewed and documentation was noted for transfer to the Emergency Room on February 9, 2017. The documenting nurse stated she contacted the identified resident's "next of kin" regarding the transfer. The Assistant Director of Nursing stated emergency contacts are listed in the order staff are to notify in case of an emergency. The staff are directed to call another contact number only if the first contact cannot be reached. The facility notified the identified resident's agent of transfer at 7:38 pm. The "agent" was listed as the fourth contact on the list. Based on record review and staff interview, it was determined the allegation could not be substantiated.

Randal Barnes, Administrator
June 6, 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 signature is written in a cursive style with a large initial "D" and a smaller "Scott" following it.

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

DS/lj