



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](mailto:fsb@dhw.idaho.gov)

May 26, 2017

Chase Gunderson, Administrator  
Meadow View Nursing And Rehabilitation  
46 North Midland Boulevard  
Nampa, ID 83651

Provider #: 135076

Dear Mr. Gunderson:

On **May 24, 2017**, a survey was conducted at Meadow View Nursing And 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 **June 6, 2017**. Failure to submit an acceptable PoC by **June 6, 2017**, may result in the imposition of penalties by **June 29, 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 **June 28, 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 **August 22, 2017**. A change in the seriousness of the deficiencies on **July 8, 2017**, may result in a change in the remedy.

Chase Gunderson, Administrator  
May 26, 2017  
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The remedy, which will be recommended if substantial compliance has not been achieved by **August 22, 2017** includes the following:

Denial of payment for new admissions effective **August 22, 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 **November 20, 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 **August 22, 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>

Chase Gunderson, Administrator  
May 26, 2017  
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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 **June 6, 2017**. If your request for informal dispute resolution is received after **June 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 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, RN, Supervisor  
Long Term Care

DS/lj  
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/24/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>MEADOW VIEW NURSING AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651</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	INITIAL COMMENTS  A Complaint Survey was conducted at the facility from May 23, 2017 to May 24, 2017.  The surveyors conducting the investigation were:  Jenny Walker, RN, Team Coordinator Brad Perry, LSW Susan Costa, RN  Abbreviations:  IDT = Interdisciplinary Team MDS = Minimum Data Set OT = Occupational Therapy ROM = Range of Motion RNA = Restorative Nursing Assistant RNP = Restorative Nursing Program SNF = Skilled Nursing Facility	F 000			
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION  (c) Mobility.  (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to	F 318	Preparation and submission of this plan of correction by, Meadow View Nursing	6/9/17	

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

TITLE

(X6) DATE

Electronically Signed

06/05/2017

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 318	<p>Continued From page 1</p> <p>ensure residents received adequate services and monitoring to prevent a decrease in ROM [Range of Motion]. This was true for 1 of 2 (#1) residents reviewed for treatment and services related to ROM. This failed practice had the potential for more than minimal harm when Resident #1 did not receive restorative therapy and adequate monitoring to prevent the deterioration of existing ROM limitations. Findings included:</p> <p>Resident #1 was admitted to the facility on 4/15/16 with multiple diagnoses, including hemiplegia related to cerebrovascular disease affecting the left dominant side, chronic pain, and muscle weakness.</p> <p>Resident #1's quarterly MDS [Minimum Data Set] assessment, dated 3/14/17, documented extensive assistance from staff was required with dressing, personal hygiene, and ROM impairments to both upper and lower extremities.</p> <p>Resident #1's annual MDS assessment, dated 4/19/17, documented Resident #1 was now totally dependent on staff for dressing, personal hygiene, and ROM impairments to both upper and lower extremities.</p> <p>An OT [Occupational Therapy] Progress and Discharge Summary, dated 9/15/16, documented Resident #1's treatment diagnosis was for generalized muscle weakness for which OT provided therapy related to an upper extremity hand grasp, beginning 8/25/16. The OT Discharge Summary documented Resident #1 had met her "goal" as of 9/15/16 and noted, "Patient's bilateral hand grasp strength is 19</p>	F 318	<p>and Rehabilitation, down not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.</p> <p>1. Resident #1 placed on therapy services and provided with splinting devices to decrease the further loss of range of motion. Care plan has been updated and resident placed on RNA. Facility has a new supervising nurse and hired a experienced RNA CNA. Training provided to staff on RNA program.</p> <p>2. DON or designee will complete weekly rounds X four weeks then monthly X six months to assess residents for any decline in ADLs. MDS coordinator to also monitor any decline in ADLs and report to IDT for intervention. RNA goals will be reviewed monthly and RNA documentation audited. Facility has a new supervising nurse and hired a experienced RNA CNA. Training provided to CNA staff on RNA program.</p> <p>Findings will be reported in QA.</p> <p>3. DON or designee will complete weekly rounds for four weeks and monthly rounds for six months to assess residents for any decline in ADLs. MDS coordinator to also monitor any decline in ADLs and report to IDT for intervention. RNA goals</p>		

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F 318	<p>Continued From page 2</p> <p>[pounds] in bilateral hands." The discharge plans and instructions for Resident #1 included, "Patient discharged to SNF [Skilled Nursing Facility] with recommendations including implementation of RNP [Restorative Nursing Program]."</p> <p>Resident #1's Restorative Nursing Program Care Plan, dated 10/1/16, documented, "Resident will maintain current level of function for ROM to upper and lower extremities over the review period [3/31/17]." The staff was to assist Resident #1 to a group exercise program provided by activities staff for 15 minutes 6-7 days a week.</p> <p>Restorative Nursing Care Flow Records, dated October 2016 through March 2017, documented Resident #1 was to be assisted by staff to the group exercise program for 15 minutes 6-7 days a week. The staff documented the minutes or refusals per day for Resident #1 for each month as follows:</p> <ul style="list-style-type: none"> <li>* October 2016: 15 days with 15 minutes each and 8 days of refusals.</li> <li>* November 2016: 14 days with 15 minutes each and 10 days of refusals.</li> <li>* December 2016: No Restorative Nursing Care Flow Record provided by the facility.</li> <li>* January 2017: 1 day with 15 minutes and 19 days of refusals.</li> <li>* February 2017: No Restorative Nursing Care Flow Record provided by the facility.</li> </ul>	F 318	<p>will be reviewed monthly and documentation audited. Facility has a new supervising nurse and hired a experienced RNA CNA. Training provided to CNA staff on RNA program. Findings will be reported and discussed in QA.</p> <p>4. DON or designee will complete weekly rounds for four weeks and monthly rounds for six months to ensure treatments are provided and completed per residents plan of care, and will also audit the completion of documentation and treatments and also assess patients for any decline in ADLs. MDS coordinator to also monitor any decline in ADLs and report to IDT for intervention. QA committee will continue to review after audits are completed.</p> <ul style="list-style-type: none"> <li>a. DON or designee will monitor and audit completion.</li> <li>b. Weekly rounds X 4 weeks, then monthly X 6.</li> <li>c. Audits will begin on 6/9/17.</li> </ul>		

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F 318	<p>Continued From page 3</p> <p>* March 2017: No Restorative Nursing Care Flow Record provided by the facility.</p> <p>Resident #1's clinical record did not include documentation the facility provided the Restorative Nursing Program as recommended by Occupational Therapy on 9/15/16.</p> <p>An IDT [Interdisciplinary Team] review of restorative nursing program in the Nurse's Notes, dated 2/20/17, documented, "Resident #1 was added on the RNA [Restorative Nursing Assistant] program on 10/1/16 for self-feeding and upper and lower body strength will monitor her gains with RNA goals." The restorative program summary did not specify or describe the restorative services provided to Resident #1, but documented, "[Resident #1] seems to be making progress towards her goals with the RNA program, will continue at this time."</p> <p>A Nurse's Note, dated 3/31/17, documented the facility's IDT review of the restorative nursing program as, "[Resident #1] was added to the RNA program on 10/1/16 for self-feeding and group exercise, resident refuses to participate. Removing from RNA at this time, OT eval to follow. Will notify doctor ..."</p> <p>The facility was unable to provide Restorative Nursing Care Flow Record documentation from 2/20/17 through 3/31/17 as evidence that Resident #1 was offered or refused to attend the Activities Program group exercise open to all residents in the facility rather than only those requiring restorative services.</p>	F 318			

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F 318	<p>Continued From page 4</p> <p>A Physician's order, dated 4/4/17, documented OT was to "evaluate and treat" Resident #1.</p> <p>An OT Care Plan, dated 4/6/17, documented Resident #1 was referred to OT by nursing/physician to address decreased ROM to the right hand and pain management.</p> <p>On 5/23/17 at 9:30 am, Resident #1 was observed sleeping in bed with a hand splint to her right hand, which was bent at the wrist and holding a stuffed animal.</p> <p>On 5/23/17 at 10:45 am, Resident #1 was observed sleeping in bed with the hand splint to her right hand and her right wrist and arm relaxed by her side.</p> <p>On 5/23/17 at 11:15 am, Resident #1 was observed flexing, with effort, her right wrist and stretching out all five digits of her right hand with the hand splint in place.</p> <p>On 5/23/17 at 12:30 pm, Resident #1 was observed eating with her left hand without difficulty. Resident #1's right arm was relaxed in her lap with the hand splint in place.</p> <p>On 5/23/17 at 3:00 pm, RN #1 said she became the Restorative Nurse on 2/13/17 and the CNA's [Certified Nursing Assistant] provided restorative services. RN #1 was unable to provide documentation that Resident #1 was receiving restorative services (Activities Program's Group Exercise) in December 2016, February 2017, and March 2017.</p> <p>On 5/25/17 at 3:00 pm, the facility provided a</p>	F 318			

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

PRINTED: 06/15/2017  
FORM APPROVED  
OMB NO. 0938-0391

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F 318	Continued From page 5 Physician's Progress Note, dated 5/24/17, that documented, "[Resident #1] had a history of a stroke affecting the right side. She has intermittent issues with reduced mobility of her right hand. She has reduced movement of her right side as well since her stroke."  The facility was unable to provide additional documentation from Resident #1's clinical record that the facility provided restorative services or therapeutic devices to prevent the development or worsening of existing ROM limitations to Resident #1's right hand.	F 318			



IDAHO DEPARTMENT OF  
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E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

June 12, 2017

Chase Gunderson, Administrator  
Meadow View Nursing And Rehabilitation  
46 North Midland Boulevard,  
Nampa, ID 83651

Provider #: 135076

Dear Mr. Gunderson:

On **May 24, 2017**, an unannounced on-site complaint survey was conducted at Meadow View Nursing And Rehabilitation. This complaint was investigated from May 22, 2017 through May 24, 2017.

During the investigation, five residents' medical records were reviewed, including that of the identified resident. Observations were made of nursing care by Licensed Nurses, Physical- (PT) and Occupational Therapy (OT) and Certified Nurse Aides (CNA) staff. The identified resident's clinical record included physician orders, treatments and medications, care plans, and progress notes by Social Services, the physician, and nursing staff. Nursing and Dietary assessments were also reviewed, as well as resident grievances and Incident and Accident Reports. Residents, facility staff and the physician were interviewed.

The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

**Complaint #ID00007464**

**ALLEGATION #1:**

The Reporting Party stated an identified resident's room smelled foul from feces on the resident's clothing and bed.

**FINDINGS:**

Inspection of resident rooms revealed no odors of feces, and no feces observed on residents' clothing or beds. None of the residents interviewed expressed concern with foul odors, or with feces on their clothing or beds. There was no documented evidence in the facility's Grievance file or Incident and Accident Reports to corroborate this concern and the allegation was not substantiated for lack of evidence.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #2:**

The facility failed to communicate with the Power of Attorney regarding the resident's need for additional clothing, information related to laboratory results and physician consultations, and when the resident was moved to another room.

**FINDINGS:**

The clinical record documented the identified resident did not have a Power of Attorney, but rather made his/her own decisions and represented his/her own interests.

A "New Inventory" list, dated February 11, 2017, documented additional clothing was brought into the facility by the resident's family.

Without the resident's permission, and in the absence of a Power of Attorney, the facility cannot share protected health information, such as results of lab work or physician consultations, with those not approved by the resident to receive such information. The facility did not provide health information to family members, who were not authorized by the resident to receive that information.

The resident's clinical record documented he/she was informed of- and consented to several room changes, including such a change in January 2017 of which his/her family was also notified.

The allegation was not substantiated and no deficiencies were cited.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #3:**

The resident was neither shaved nor bathed for six days.

**FINDINGS:**

The identified resident's personal belongings inventory list he/she was in possession of two electric razors and was care planned to receive grooming and hygiene assistance from staff through the Restorative Nursing Program. The identified resident was discharged from this program, however, due to his/her refusal to participate.

Bathing records documented the identified resident was offered regularly scheduled bathing, which he/she refused on multiple occasions. The resident's care plan included interventions to promote regular hygiene practice, cues for morning and evening cares, oral care, grooming and dressing. The care plan included interventions to address the identified resident's resistance to grooming and to minimize his agitation.

The resident's clinical record documented he/she received three showers in April 2017 with refusals recorded for eight days that month. In May 2017, the resident received two showers and refused bathing on five occasions. The resident's clinical record documented he/she was unsuccessfully reapproached after each refusal.

The resident had a moderate growth of beard, a moustache which covered his/her mouth, and uncombed hair. A noticeable body odor emanated from the resident. The resident stated he/she felt his/her hygiene was adequate, and that he/she was independent with grooming and personal hygiene. He/She stated he/she wanted to bathe on his/her schedule, rather than on a schedule set by the facility.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #4:**

The Reporting Party stated the facility's private Dining Room was dirty.

**FINDINGS:**

The dining room was observed clean on numerous occasions throughout the complaint investigation. Neither residents nor staff expressed concerns with the dining room's level of cleanliness.

The allegation was not substantiated and no deficiencies were cited.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #5:**

The facility did not ensure physician orders were followed in regards to medication administration, assistance with Activities of Daily Living (ADLs), laboratory tests were completed, and fluid restrictions were enforced.

**FINDINGS:**

The resident's clinical record documented medications were administered per physician order except on those occasions when the identified resident refused the medications; assistance with ADLs was provided except on those occasions the identified resident refused assistance from staff; physician-ordered laboratory work was refused by the identified resident on two occasions, of which the resident's physician was informed; and the resident's fluid restriction was discontinued in February 2017 due to the resident's "noncompliance."

The allegation was not substantiated for lack of evidence.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #6:**

The Reporting Party stated the facility isolated the resident for inappropriate behavior.

**FINDINGS:**

The facility provided care plan interventions inappropriate behaviors that did not include involuntary isolation. A Psycho-Pharmacological Record documented that when the identified resident made inappropriate gestures or statements, staff were to set boundaries and, if those inappropriate behaviors occurred in the dining room, staff were to assist the resident to eat in his/her room to avoid adverse effects on the facility's other residents. In 2017, the resident was assisted with his/her meals in his/her room on four occasions in February, 21 occasions in March, and eight occasions in April.

When asked about his/her removal from the dining room to eat his/her meals privately, the identified resident stated he/she not feel he/she was being isolated. The resident stated he/she was treated "fine" at the facility, and that he/she was able to leave any time he/she desired.

The allegation was not substantiated and no deficiencies were cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

The resident was not encouraged to use a walker, but rather was in a wheelchair "all the time."

FINDINGS:

The identified resident's clinical record documented orders for Physical Therapy five times weekly for four weeks for strengthening, gait, balance, transfers, and safety. Physical Therapy was discontinued in January 2017.

The resident's care plan documented was able to bear his/her own weight as tolerated and directed staff to "encourage resident to ambulate with walker."

An Orthopedic Progress Note documented the resident continued to be "weight-bearing as tolerated" and was able to ambulate independently, but preferred to use a wheelchair.

The identified resident stated he/she walked to the dining room three times a day, but preferred to use a wheelchair.

No allegation was not substantiated and no deficiencies were cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

A Certified Nursing Aide was talking on a cell phone and was rude when the Reporting Party inquired about the resident wearing dirty clothes. The Reporting Party requested clean linen, which the Certified Nursing Aide provided, but he/she did not assist with changing the resident's bedding.

Chase Gunderson, Administrator  
June 12, 2017  
Page 6 of 6

**FINDINGS:**

During the provision of resident cares, Certified Nursing Aides were not observed using cell phones and their demeanor was courteous and friendly.

There are no regulatory requirements related to staff use of cell phones or "rude behavior" toward visitors.

The allegation was not substantiated and no deficiencies were cited.

**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

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](mailto:fsb@dhw.idaho.gov)

June 6, 2017

Chase Gunderson, Administrator  
Meadow View Nursing and Rehabilitation  
46 North Midland Boulevard  
Nampa, ID 83651

Provider #: 135076

Dear Mr. Gunderson:

On **May 24, 2017**, an unannounced on-site complaint survey was conducted at Meadow View Nursing And Rehabilitation. The complaint was investigated during an on-site complaint survey conducted May 23, 2017 through May 24, 2017.

The clinical record of the identified resident and four other residents' records were reviewed. The facility's Grievance file and the facility's Incident and Accidents file from February 2017 to May 2017 was also reviewed.

The identified resident, several other residents, several Certified Nursing Aides (CNAs) and nurses, and the Resident Services Designee were interviewed for various concerns.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007473**

**ALLEGATION #1:**

The Reporting Party said an Interested Party was not informed of an identified resident's changes of condition when the resident fell, vomited blood, experienced jaw and foot pain, and was transported to a local emergency room.

**FINDINGS:**

The clinical record of the identified resident, including Incident and Accident reports, did not identify concerns with proper notification to the appropriate responsible party. The clinical records of four other residents did not identify concerns with change of condition notifications. The facility's Grievance files did not identify concerns with proper notification to the appropriate responsible party.

The identified resident said he/she did not have concerns with notification to the appropriate responsible party. Several other residents said they did not have concerns with change of condition notifications. Two nurses said they "always" notified the appropriate responsible party when a resident experienced a change of condition, based on resident choice and the appropriate power of attorney documents, which were in the resident's chart. The Resident Service Designee in the Social Services department said interested parties can receive resident change of condition notifications as long as residents approve the notification and/or proper power of attorney documents were in the residents' charts.

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

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #2:**

An Interested Party who called the facility was not provided an identified resident's list of medications given to the resident on a specified day.

**FINDINGS:**

The clinical record of the identified resident did not identify concerns with facility staff providing medical information to the appropriate responsible party. The clinical records of four other residents, as well as the facility's Grievance file, did not identify concerns with providing medical information to the appropriate responsible party.

The identified resident and several other residents said he/she/they did not have concerns with facility staff providing medical information to the appropriate responsible party. Two nurses said they provided medical information to the appropriate responsible party.

Chase Gunderson, Administrator  
June 6, 2017  
Page 3 of 3

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

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #3:**

An Interested Party, who spoke only Spanish, was not allowed to speak with an identified resident after calling the facility four times on a particular day.

**FINDINGS:**

The identified resident said he/she did not have concerns with others contacting him/her because he/she had a cellphone. One other resident said he/she did not have concerns with receiving calls from others outside of the facility. Two of three Certified Nursing Aides and one out of two nurses interviewed said they spoke Spanish. Several staff members said other staff members who speak Spanish are readily available to interpret when a Spanish-only speaker contacts the facility.

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

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

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

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

DS/lj



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PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

September 21, 2017

Chase Gunderson, Administrator  
Meadow View Nursing and Rehabilitation  
46 North Midland Boulevard  
Nampa, ID 83651

Provider #: 135076

Dear Mr. Gunderson:

On **May 24, 2017**, an unannounced on-site complaint survey was conducted at Meadow View Nursing and Rehabilitation. The complaint investigation survey was conducted at the facility on May 23, 2017 and May 24, 2017.

Immediately after entering the facility on the first day of the survey, the survey team conducted a general tour of residents' rooms and common areas. Throughout survey, five individual residents and all residents in general were observed for quality of care, including appropriate medications, contractures, and positioning in bed and wheelchairs.

The clinical record of the identified resident and four other residents' records were reviewed. The facility's Grievance files, Incident and Accident reports, and Certified Nurse Aide (CNA) training were reviewed.

Interviews were conducted with the identified resident and several other residents. Several direct care staff, including nurses, CNA's, Occupational Therapists, and a Therapy Assistant, were interviewed. The Medical Director, Rehabilitation Manager, and the Director of Nursing were interviewed. The interviews included questions of quality of care issues.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007502**

ALLEGATION #1:

The Reporting Party said an identified resident receives Norco, Depakote, and a beta blocker. The Reporting Party questioned whether the identified resident required these medications as there has been a noted increase in lethargy and an overall deterioration in the identified resident's condition.

FINDINGS:

The identified resident was observed throughout survey and no concerns were identified.

The identified resident's clinical record was reviewed and no concerns were identified.

The Medical Director was interviewed and reviewed the identified resident's clinical record and no concerns were identified.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

An identified resident developed a contracture to his/her right hand.

FINDINGS:

Based on observation, record review, and staff interview, it was determined the allegation was substantiated and the facility was cited at F318. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

The facility's staff did not receive adequate training to prevent or manage contractures.

FINDINGS:

Based on observation, record review, and staff interview, it was determined the allegation was substantiated and the facility was cited at F318. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

The identified resident has poor positioning while in bed and is unable to reposition independently.

FINDINGS:

The identified resident was observed throughout survey and no concerns were identified. The identified resident's clinical record was reviewed and no concerns were identified.

Several CNAs were interviewed regarding positioning and no concerns were identified.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The identified resident is positioned poorly by the facility's staff while in a wheelchair.

FINDINGS:

The identified resident was observed sitting in a wheelchair and no concerns were identified.

The identified resident's clinical record was reviewed and no concerns were identified.

The Rehabilitation Manager, Occupational Therapist, and Certified Occupational Therapist Aide were interviewed regarding the identified resident's positioning in the wheelchair and no concerns were identified.

Chase Gunderson, Administrator  
September 21, 2017  
Page 4 of 4

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

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,

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

DS/lj