



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
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E-mail: fsb@dhw.idaho.gov

June 8, 2017

Joseph Rudd, Administrator
Riverview Rehabilitation
3550 West Americana Terrace
Boise, ID 83706-4728

Provider #: 135139

Dear Mr. Rudd:

Congratulations to both you and your staff on your deficiency-free survey. In today's world with numerous regulations, it is indeed impressive to see a facility functioning as a team at this level.

Continuing to meet the needs of your residents – while recognizing and meeting the administrative needs of your business – is a daily commitment to quality ongoing assessment, care planning and consistent provision of services to each and every client. The greater challenge, of course, is to be able to work as a team to provide this high level of caring and service day after day, week after week, year after year.

Again, **Congratulations** to you and your staff for a job well done, and I challenge you to keep this same high standard in the coming year.

Sincerely,

DEBBY RANSOM, R.N., R.H.I.T.
Bureau Chief



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June 8, 2017

Joseph Rudd, Administrator
Riverview Rehabilitation
3550 West Americana Terrace
Boise, ID 83706-4728

Provider #: 135139

Dear Mr. Rudd:

On **June 1, 2017**, a survey was conducted at Riverview 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. Your facility was found to be in substantial compliance with federal health care requirements regulations during this survey.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing no Medicare and/or Medicaid deficiencies.

However, your facility still has a state licensure deficiency that requires submission of a Plan of Correction. A Statement of Deficiencies and Plan of Correction, State Form listing licensure health deficiencies is enclosed. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign the State Form Statement of Deficiencies and Plan of Correction in the space provided.

Joseph Rudd, Administrator
June 8, 2017
Page 2 of 2

Your Plan of Correction (POC) for the deficiencies must be submitted by **June 19, 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.
- Include dates when corrective action will be completed in column (X5).

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

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

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/lj

Joseph Rudd, Administrator
June 8, 2017
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Enclosures

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

PRINTED: 06/26/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/01/2017
NAME OF PROVIDER OR SUPPLIER RIVERVIEW REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 WEST AMERICANA TERRACE BOISE, ID 83706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>A survey team conducted a recertification survey at Riverview Rehabilitation from 5/30/17 through 6/1/17. The facility was found to be un substantial compliance with 42 CFR Part 483 Requirement for Long Term Care Facilities.</p> <p>The surveyors conducting the survey were: Edith Cecil, RN, Team Coordinator Susan Costa , RN</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

06/13/2017

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.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001665	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/01/2017
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3550 WEST AMERICANA TERRACE BOISE, ID 83706
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the State licensure survey of your facility completed 5/30/17 through 6/1/17.</p> <p>The surveyors conducting the survey were: Edith Cecil, RN, Team Coordinator Susan Costa, RN</p> <p>Survey Abbreviations: ICC = Infection Control Committee ICN = Infection Control Nurse</p>	C 000		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of Infection Control Committee (ICC) attendance records, it was determined the facility failed to ensure the Pharmacist and a representative from the housekeeping services participated in ICC meetings at least quarterly. The failure created the potential for negative outcomes for residents, visitors, and staff in the facility. Findings included: On 5/31/17 at 1:00 pm, the facility's Infection Control Program was reviewed with the Infection Control Nurse, (ICN.) The ICN stated the ICC met quarterly. The ICN provided the ICC attendance records dated May 2016 through April 2017. The records documented the Pharmacist participated in May 2016. The ICC attendance</p>	C 664	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Riverview Rehabilitation does not stipulate or admit that the deficiencies listed herein, on this State Form exist, nor does this facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies.</p> <p>C664 1. On June 13, 2017 the facility Infection Control Committee met, including the medical director, administrator, pharmacist, dietary services supervisor, director of nursing, housekeeping services</p>	6/13/17

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 06/13/17
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001665	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/01/2017
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C 664	Continued From page 1 records did not identify any meeting in which representative from housekeeping participated.	C 664	representative, and maintenance services representative to review infections being tracked in the facility by the facility Infection Preventionist. 2. On June 13, 2017 the facility infection Control Committee reviewed infection patterns. No trends were identified and no negative outcomes were noted. 3. On June 13, 2017 members of the Infection Control Committee were educated by the facility Infection Preventionist regarding their appointment to the committee and responsibilities as a committee member in accordance with IDAPA 16.03.02.150.02 4. Beginning June 13, 2017 attendance at the facility Infection Control Committee meeting will be presented in the facility QAPI meeting monthly for three months to ensure an ongoing pattern of attendance is maintained by those Infection Control Committee members whose attendance is required in accordance with state rule.	