



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSS BARRON – 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
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April 4, 2018

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

Provider #: 135068

Dear Mr. Lewis, Jr.:

On **March 23, 2018**, 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.

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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 16, 2018**. Failure to submit an acceptable PoC by **April 16, 2018**, may result in the imposition of penalties by **April 26, 2018**.

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 27, 2018 (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 21, 2018**. A change in the seriousness of the deficiencies on **May 7, 2018**, 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 **June 23, 2018** includes the following:

Denial of payment for new admissions effective **June 23, 2018**. [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 23, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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 23, 2018** 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:

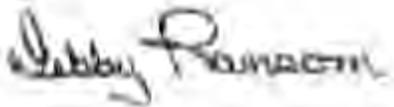
- BFS Letters (06/30/11)

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

This request must be received by **April 16, 2018**. If your request for informal dispute resolution is received after **April 16, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards

DR/lj
Enclosures

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

PRINTED: 04/20/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/23/2018
NAME OF PROVIDER OR SUPPLIER PARKE VIEW REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318		
(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 the federal recertification and complaint survey conducted at the facility from March 19, 2018 through March 23, 2018. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Edith Cecil, RN Cecilia Stockdill, RN Wendi Gonzales, RN Survey Abbreviations: CNA = Certified Nursing Assistant DON = Director of Nursing LN = Licensed Nurse LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment mg/dL = milligrams/deciliters RN = Registered Nurse w/c = wheelchair	F 000			
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information	F 655		4/20/18	

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

TITLE

(X6) DATE

Electronically Signed

04/13/2018

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 655	<p>Continued From page 1</p> <p>necessary to properly care for a resident including, but not limited to-</p> <p>(A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.</p> <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <p>(i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <p>(i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff and family member interviews, it was determined the facility failed to provide a written copy or summary of the baseline care plan to residents and their representatives. This was true for 2 of 5 sample residents (#222 and #224) reviewed for baseline</p>	F 655	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Parke View Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to</p>		

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F 655	<p>Continued From page 2</p> <p>care plans. This created the potential for harm should the residents and their representatives not be included in planning the residents' care and be informed of the baseline plan of care. Findings include:</p> <p>1. Resident #222 was admitted on 3/7/18 with multiple diagnoses, including urinary tract infection and adult failure to thrive.</p> <p>Resident #222's care plan documented it was initiated on 3/7/18. There was no documentation that a copy or summary of the baseline care plan was provided to the resident and/or her representative.</p> <p>On 3/20/18 at 12:00 PM, Resident #222 was unable to complete an interview due to being extremely hard of hearing and her lack of ability to understand questions being asked.</p> <p>On 3/20/18 at 12:14 PM, Resident #222's representative said she was not invited to a care plan meeting and the facility did not provide written documentation to her regarding a care plan.</p> <p>2. Resident #224 was admitted on 3/15/18 with multiple diagnoses, including bronchiectasis (lung disease resulting in difficulty breathing) and essential hypertension (high blood pressure).</p> <p>Resident #224's baseline care plan documented it was initiated on 3/15/18. There was no documentation that a copy or summary of the care plan was provided to the resident.</p> <p>On 3/20/18 at 4:44 PM, RN #1 stated whoever</p>	F 655	<p>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> <p>1. Resident #224 had a family care conference on 3/16/18. Resident #222 had a family care conference on 3/9/18. Copies of the Care plans were provided to resident #224 and #222 on 3/22/18.</p> <p>2. All residents have the potential to be affected.</p> <p>3. Education to be provided to IDT regarding providing a baseline care plan summary to the resident or representative. Family/IDT conferences will be completed and a copy of the baseline care plan will be offered to the family and resident. IDT will have resident/family sign a form that they were offered/received a copy of the base line care plan.</p> <p>4. DNS/designee will audit base line care plans being offered to the resident/family weekly times 4 weeks then monthly times 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.</p>		

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F 655	Continued From page 3 admits the resident initiates the care plan based on the nursing assessment. RN #1 said he was involved with completing the baseline care plan for Resident #224. He said he did not know what steps were taken with the baseline care plan after he completed it and he did not know if the resident received a copy of the baseline care plan.	F 655			
F 656 SS=D	On 3/20/18 at 4:56 PM, the LSW (Licensed Social Worker) said the facility was not providing a copy of the baseline care plan to residents. Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		4/20/18	

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F 656	<p>Continued From page 4</p> <p>recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure comprehensive resident-centered care plans included the use of oxygen and side rails, and provided directions to staff regarding pressure relief interventions and when to assist a resident to bed and to the toilet. This was true for 3 of 19 sample residents (#4, #56, and #222) whose comprehensive care plans were reviewed. This failure created the potential for residents to receive inappropriate or inadequate care with a subsequent decline in health. Findings include:</p> <p>1. Resident #222 was admitted on 3/7/18 with multiple diagnoses, including urinary tract infection and adult failure to thrive.</p> <p>Resident #222's Order Summary Report, dated</p>	F 656	<p>1. Residents #4, #56, and #222 had missing items within the resident comprehensive care plan. Resident number 4's care plans was updated as needed. Resident number 56's care plan was updated as needed. Resident number 222's care plan was updated as needed.</p> <p>2. All residents have the potential to be affected.</p> <p>3. Education provided to IDT and LNs. IDT will review and update care plans for Comprehensive Assessments.</p> <p>4. DNS/designee will audit implementation of care plans for pressure relief interventions, oxygen, and side rails weekly times 4 weeks and then monthly times 3 months. The audits will be reviewed monthly by the QAA committee</p>		

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F 656	<p>Continued From page 5</p> <p>3/22/18, documented oxygen was ordered on 3/9/18 and staff were to keep her oxygen saturation (the percentage of oxygen in the blood) above 90%.</p> <p>Resident #222's care plan did not document the use of oxygen or monitoring her oxygen saturation levels.</p> <p>Resident #222's Daily Skilled notes, dated 3/10 through 3/20/18, documented oxygen at 2 to 2.5 liters per minute and oxygen saturation levels from 92% to 98%.</p> <p>On 3/19/19 at 11:31 AM, Resident #222 was in her room wearing oxygen at 2 liters per minute by nasal cannula.</p> <p>On 3/22/18 at 2:51 PM, the DON said Resident #222's care plan did not address her use of oxygen.</p> <p>2. Resident #56 was admitted on 2/8/18 with multiple diagnoses, including muscle weakness.</p> <p>Resident #56's Admission MDS assessment, dated 2/16/18, documented he was cognitively intact and required 1 person physical assistance with bed mobility and transfers.</p> <p>Resident #56's Order Summary Report, dated 3/1/18, documented "May use assistive devices based on admission assessment" was ordered on 2/9/18.</p> <p>Resident #56's Restraint/Enabling Device/Safety Device Evaluation, dated 2/9/18, documented the recommended devices included half side rails to</p>	F 656	<p>until it has been determined by the committee that the systems are effective.</p>		

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F 656	<p>Continued From page 6</p> <p>his bed.</p> <p>On 3/20/18 at 10:04 AM, Resident #56 was observed with bilateral half side rails on his bed. At that time, Resident #222 said he did not remember discussing side rails with the facility staff and they were "just there."</p> <p>On 3/21/18 at 3:29 PM, the MDS nurse said Resident #56's care plan did not include the use of side rails and they should be addressed on the care plan.</p> <p>3. Resident #4 was readmitted to the facility on 11/23/17 with a diagnosis of a traumatic brain injury related to a hemorrhagic stroke with right side paralysis.</p> <p>The quarterly MDS, dated 12/9/17, documented Resident #4 required extensive assist from staff for bedmobility, transfers, and toileting.</p> <p>Resident #4's current Care Plan, dated 11/23/17, documented Resident #4 required staff assistance for bed mobility, transfers, and toileting. The care plan did not provide direction to staff regarding when to provide toileting assistance, when Resident #4 was to be assisted to bed, or how to provide pressure relief strategies to prevent Resident #4 from remaining seated in her wheelchair for extended periods of time.</p> <p>On 3/19/18 at 12:44 PM, Resident #4 was observed sitting in her w/c in the dining room.</p> <p>On 3/20/18 at 8:48 AM, Resident #4 was observed sitting in her w/c. At 11:30 AM,</p>	F 656			

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F 656	Continued From page 7 Resident #4 was observed laying in her bed. On 3/21/18 at 3:00 PM, Resident #4 was observed laying in her bed. On 3/23/18 at 10:00 AM, LPN #3 stated that staff assisted Resident #4 with toileting and personal cares every 2 hours and assisted Resident #4 to lay down routinely after lunch and occasionally after breakfast.	F 656			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		4/20/18	

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F 657	<p>Continued From page 8</p> <p>comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure residents' care plans were revised and updated to maintain consistency and accuracy. This was true for 2 of 19 sample residents (#25 and #56) whose care plans were reviewed. This had the potential for resident harm if cares and/or services were not provided due to incorrect information. Findings include:</p> <p>1. Resident #56 was admitted on 2/9/18 with multiple diagnoses, including chronic kidney disease.</p> <p>Resident #56's Order Summary Report, dated 3/1/18, directed staff to weigh him every Tuesday on day shift.</p> <p>Resident #56's current care plan documented interventions related to chronic kidney disease that directed staff to monitor, document, and report to the physician a weight gain of over two pounds per day. The care plan related to hypertension directed staff to obtain Resident #56's weight at least monthly. The care plan related to nutrition directed staff to monitor and record weights with no specified frequency.</p> <p>On 3/22/18 at 3:13 PM, the MDS nurse said she should have corrected Resident #56's care plan to read plus or minus three pounds in a week or five pounds in a month.</p> <p>Resident #56's care plan contained three</p>	F 657	<p>1. Resident #25's care plan was updated as needed. Resident #56's care plan was updated as needed.</p> <p>2. All residents have the potential to be affected.</p> <p>3. Education provided to IDT and LNS. IDT and LNS will review and revise care plans as needed.</p> <p>4. DNS/Designee will audit a sampling of 10 order changes weekly times 4 weeks and then monthly times 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.</p>		

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F 657	<p>Continued From page 9</p> <p>different directions to staff regarding monitoring his weight, and none of the directions were consistent with physician orders.</p> <p>2. Resident #25 was readmitted to the facility on 11/13/14 with multiple diagnoses, including Parkinson's disease.</p> <p>Resident #25's current communication care plan, dated 9/26/17, did not document she had a hearing device.</p> <p>Resident #25's quarterly MDS assessment, dated 1/3/18, documented she used a hearing device.</p> <p>On 3/19/18 at 3:22 PM and on 3/21/18 at 9:17 AM, Resident #25 had a hearing device in her left ear. At the time of the second observation Resident #25 said she had been given the amplifier several weeks ago by a family member and used it when she wanted. She said either she put it in her ear herself or staff helped her put it in.</p> <p>On 3/21/18 at 9:09 AM, LPN #1 said Resident #25 used a hearing amplifier that was given to her by a family member for Christmas. LPN #1 said Resident #25's care plan did not document she had a hearing device.</p> <p>On 3/21/18 at 9:23 AM, CNA #1 said Resident #25 used a hearing device in her left ear and either staff or the resident put the device in her ear.</p> <p>On 3/21/18 at 11:22 AM, the Social Worker said Resident #25's family member had purchased the amplifier and said the care plan did not document Resident #25's use of a hearing</p>	F 657			

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F 657	Continued From page 10 device.	F 657			
F 658 SS=D	<p>Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)</p> <p>§483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of medical records, facility policy, and Fall Scene Investigation Reports, it was determined the facility failed to ensure professional standards of practice were followed for 2 of 19 sample residents (#222 and #225) whose care plans were reviewed. This was true when neurological checks were not consistently completed after a resident's fall, and physician orders were not followed for a resident experiencing low blood sugar readings. This failed practice created the potential for harm should changes in neurological status go undetected or should the resident experience adverse consequences from low blood sugar. Findings include:</p> <p>1. The facility's Policy/Procedure for Vital Signs, dated 5/07, documented "...residents involved in a possible head injury incident may warrant neuro-checks every 15 minutes for a period of time..."</p> <p>Resident #222 was admitted on 3/7/18 with multiple diagnoses, including difficulty in walking and unsteadiness on feet.</p> <p>Resident #222's current care plan documented</p>	F 658	<p>1. Corrective actions provided for affected resident number 225 were: Staff in-serviced to appropriately follow DM protocol. Corrective actions for affected resident #224 were: Neurological checks were performed on resident #224 Q15 minutes times 4, Q30 minutes times 4, and Q 4 hours times 6 without noted changes. Staff in-serviced on neuro check procedure.</p> <p>2. All residents who are diabetic and have blood glucose monitoring orders have the potential to be affected. All residents who have an unwitnessed fall or head injury have the potential to be affected.</p> <p>3. Education provided to licensed nurses related to diabetic protocols. Staff in-serviced on neuro check procedure. All residents who are diabetic and have blood glucose monitoring orders were reviewed to ensure blood glucose monitoring protocol were in place and being followed.</p> <p>4. DNS/Designee will audit blood sugars and neuro check forms 5 times per week for 4 weeks and then weekly times 4 weeks for DM protocols and neuro check</p>	4/20/18	

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F 658	<p>Continued From page 11 she was at risk for falls.</p> <p>A Fall Scene Investigation Report, dated 3/13/18, documented Resident #222 had an unwitnessed fall and was found on the floor in her bathroom on 3/13/18 at 2:30 AM. Neurological checks were initiated at the time of the fall.</p> <p>A Nursing Progress Note, dated 3/13/18 at 2:30 AM, documented the nurse and CNA heard a "thump" and found Resident #222 on the floor in the bathroom. Resident #222 was sitting on the floor next to the toilet with her back against the wall and her legs extended "straight out." The resident said she was going to the bathroom and "just fell." Neurological checks were initiated at that time.</p> <p>Resident #222's Glasgow Coma Scale Neurological Check Sheet, dated 3/13/18, documented the neurological check protocol as follows: every 15 minutes for 1 hour, every 30 minutes for 2 hours, every 1 hour for 4 hours, then every 4 hours for 1 day. The 3/13/18 Neurological Check Sheet showed Resident #222 was to receive hourly neurological checks on 3/13/18 at 6:15 AM, 7:15 AM, 8:15 AM, 9:15 AM, and then a check in 4 hours at 1:15 PM. The Neurological Check Sheet did not include documentation of neurological checks completed at those time points. The Neurological Check Sheet did not include documentation of checks completed between 5:15 AM and 5:15 PM, on 3/13/18.</p> <p>On 3/14/18 at 5:15 AM, the Neurological Check Sheet documented Resident #222 was "Sleeping."</p>	F 658	<p>procedures are being followed. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.</p>		

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F 658	<p>Continued From page 12</p> <p>On 3/22/18 at 2:51 PM, the DON said the neurological checks on 3/13/18 were not consistently completed for Resident #222.</p> <p>2. Resident #225 was admitted on 3/9/18 with multiple diagnoses, including Type 2 diabetes mellitus.</p> <p>Resident #225's care plan interventions, initiated 3/9/18, directed staff to check blood sugar levels as ordered by the physician, and to monitor/document/report to the physician as needed for signs/symptoms of hypoglycemia (low blood sugar).</p> <p>Resident #225's Order Summary Report, dated 3/1/-3/31/18, documented the following:</p> <ul style="list-style-type: none"> * Blood sugar checks as needed * Check blood sugar before meals and at bedtime * Call the physician if blood sugar below 70 mg/dL (milligrams/deciliters) or if over 360 mg/dL * If the blood sugar is below 70 and the resident is awake/able to swallow, "give 4 oz. (ounces) juice/pop, 8 oz. non-fat milk, 1 TBSP (tablespoon) sugar." Recheck BS (blood sugar) in 15 minutes, if still below 70 repeat steps above, if BS below 70 and pt (patient) is non-responsive follow RSO" (routine standing orders). <p>Resident #225's Weights and Vitals Summary documented a blood sugar reading of 57 mg/dL on 3/1/18 at 6:44 AM. The next blood sugar level documented on 3/1/18 was 175 mg/dL at 11:46 am.</p>	F 658			

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F 658	<p>Continued From page 13</p> <p>A Daily Skilled Documentation assessment, dated 3/1/18 at 9:20 AM, documented Resident #225 "Takes insulin for DM (diabetes mellitus), had low BG (blood glucose) early AM but resolved. Tolerating insulin well." There was no documentation that the physician was notified of the resident's blood sugar reading or the physician orders were followed regarding low blood sugar.</p> <p>On 3/23/18 at 8:50 AM, RN #2 said if Resident #225's blood sugar was less than 75 she should notify the physician, but it was not done regarding Resident #225's low blood sugar on 3/1/18 at 6:44 AM. RN #2 said there was a protocol to follow that directed staff to give juice to the resident and recheck the blood sugar, which she did and Resident #225's blood sugar level was better.</p> <p>On 3/23/18 at 9:08 AM, the DON said the nurse should have followed Resident #225's orders and rechecked the blood sugar. The DON said she did not see where it was documented the protocol was followed or that the physician was notified of Resident #225's low blood sugar reading on 3/1/18.</p> <p>On 3/23/18 at 9:19 AM, RN #2 said it was documented on the 3/1/18 Daily Skilled Documentation assessment that the low blood sugar was resolved, although actions taken to resolve the issue were not documented.</p> <p>A faxed document, dated 3/24/18, was received on 3/26/18 at 1:05 PM and was signed by RN #2. The faxed document provided information that Resident #225's blood sugar was 57 on 3/1/18 at</p>	F 658			

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F 658	Continued From page 14 6:44 AM. Resident #225 was given 4 ounces of apple juice and one-half cup of pudding, his blood sugar level was rechecked and "resolved" but did not document his blood sugar level at the time of the recheck. On 3/26/18 at 4:15 PM, the DON confirmed the documentation regarding Resident #225's low blood sugar level on 3/1/18 did not include the time his blood sugar was rechecked, the blood sugar level upon re-check, and that the physician was notified of the low blood sugar level on 3/1/18 according to the resident's blood sugar protocol.	F 658			
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident and Resident Group interview, test tray evaluation and staff interviews, it was determined the facility failed to serve palatable food. This affected 11 of 11 residents interviewed for food palatability (#2, #3, #5, #18, #19, #20, #23, #24, #34, #35, #46), and had the potential to affect 57 other residents who dined in the facility. This failed practice had the potential to negatively affect residents' nutritional status and psychosocial well-being related to	F 804	1. Residents identified were surveyed to discuss preferences and concerns. 2. All residents dining in the facility have the potential to be affected by this practice. 3. Dietary staff were in-serviced regarding food quality and preparation techniques. Changed product of meat identified as not having flavor. 4. Administrator/Designee will audit a test	4/20/18	

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F 804	Continued From page 15 unpalatable food. Findings include: On 3/19/18 at 11:40 AM, Resident #20 said the meat was so bad that he had become a vegetarian. On 3/19/18 at 12:51 PM, Resident #34 was observed eating her lunch, which included meatloaf. She said the food was usually cold and the meats were bland, including the meatloaf she had been eating. On 3/19/18 at 2:36 PM, Resident #46 said he often ordered food from outside of the facility because the facility food was so bad. On 3/21/18 at 10:30 AM, during the Resident Group interview, Resident #2, #3, #5, #18, #19, #23, #24, #34, and #35 said the meat and food was not flavorful. On 3/21/18 at 12:58 PM, a lunch meal test tray was evaluated by three surveyors with the Certified Dietary Manager (CDM) and Registered Dietician (RD) present. The chicken fried steak with gravy had a temperature of 148.6 Fahrenheit and the RD said the meat had a nice flavor. The CDM said she liked the meat, which was a frozen pre-made formed meat product and was heated prior to serving. The three surveyors evaluated the meat which was found to have a strong flour-like taste and after-taste, and the meat without the gravy was found to be bland.	F 804	tray 3x/week for 4 weeks, then monthly for 3 months. Food Satisfaction surveys will be done for 5 residents/week for 4 weeks, then 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 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is	F 842		4/20/18	

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

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F 842	<p>Continued From page 16</p> <p>resident-identifiable to the public.</p> <p>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <p>(i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized</p> <p>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p>	F 842			

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F 842	Continued From page 17 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure accurate and complete clinical records were maintained for each resident. This was true for 2 of 19 sample residents (#42 and # 225) whose records were reviewed. This created the potential for harm should inappropriate care and/or treatment be provided based on inaccurate information in the resident's clinical record. Findings include:	F 842	1. Corrective action for affected residents: Inaccurate UDA was struck out. Nurse credentials were verified and will no longer show as CNA. 2. All residents can be affected by this practice. 3. Education provided to nursing staff regarding MAR documentation and side rail assessment completion. All licensed staff will have their credentials verified upon hire.		

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F 842	<p>Continued From page 18</p> <p>1. Resident #42 was admitted on 10/17/16 with multiple diagnoses, including quadriplegia (paralysis of the arms and legs) and muscle spasm.</p> <p>Resident #42's 2/6/18 quarterly MDS assessment documented side rails were not used.</p> <p>Resident #42's Restraint/Enabling Device/Safety Device Review assessment, dated 3/18/18, documented the only current measures/devices included a reclining electric wheelchair.</p> <p>Resident #42's Restraint/Enabling Device/Safety Device Review assessment, dated 12/14/17, documented current measures/devices included a reclining electric wheelchair and left and right top half side rails. The recommendations included "Resident is again using left and right top half side rails for air bed use. Side rails provide him a sense of security and he feels safer with their use."</p> <p>On 3/21/18 at 8:50 AM, the Environmental Services Manager said Resident #42 did not use side rails. Resident #42 was laying in bed on an air mattress with bolstered sides and the side rails were secured in the down position.</p> <p>On 3/21/18 at 4:10 PM, the DON said the 12/14/17 assessment was inaccurate. The DON said Resident #42 was did not use side rails and that side rails had not been implemented since admission.</p> <p>2. Resident #225 was admitted on 3/9/18 with multiple diagnoses, including Type 2 diabetes mellitus.</p>	F 842	<p>4. DNS or designee will perform audits of a sample of 5 residents that their UDAs are accurate weekly for 4 weeks and monthly for 3 months. DNS or designee will perform blood sugar audits 5 times per week for 4 weeks and then weekly times 4 weeks for DM protocols. The audits will be reviewed monthly by the QAA committee until it has be determined by the committee that the systems are effective.</p>		

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F 842	Continued From page 19 a. Resident #225's Weights and Vitals Summary documented his blood sugar was 13 mg/dL on 3/1/18 at 11:52 AM. On 3/23/18 at 9:08 AM, the DON said the documented blood sugar of 13 mg/dL on 3/1/18 must be a "typo" and she would check into it. On 3/26/18 at 1:05 PM, Resident #225's Weights and Vitals Summary was received via fax and documented that "13 was an inaccurate documentation for BS (blood sugar). This 13 was units [of insulin] given for BS documented [on] 3/1/18 [at] 11:46 [for] BS 175." b. Resident #225's Daily Skilled Documentation assessment, dated 3/1/18 at 9:20 AM, was signed by facility staff with a title of Certified Nursing Assistant. On 3/26/18 at 4:15 PM, the DON said the facility staff who signed the Daily Skilled Documentation assessment on 3/1/18 was a Registered Nurse, and a Certified Nursing Assistant would not complete a Daily Skilled Documentation assessment. The DON said she did not know why the signature title was documented as Certified Nursing Assistant next to the staff member's name who completed the document.	F 842			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		4/20/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/23/2018
NAME OF PROVIDER OR SUPPLIER PARKE VIEW REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318		
(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 880	Continued From page 20 development and transmission of communicable diseases and infections. §483.80(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: §483.80(a)(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; §483.80(a)(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 infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 880			

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F 880	<p>Continued From page 21</p> <p>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>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(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 observations, staff interviews, and policy review, it was determined the facility failed to ensure licensed nursing staff properly sanitized their hands before passing medications, after handling contaminated equipment, and after removing gloves. This was true for 2 of 5 sampled residents (#10 and #49) observed for medication pass and 1 of 1 residents (#63) sampled for a dressing change. The deficient practices created the potential for the spread of infectious organisms from cross contamination which could harm all residents residing in the facility. Findings include:</p>	F 880	<ol style="list-style-type: none"> 1. Identified staff members educated on universal precautions. Identified staff members were checked off on competency related to universal precautions. 2. All residents can be affected by this practice. 3. Education provided to nursing staff regarding universal precautions, hand washing, and infection control practices. 4. DNS or designee will perform hand washing observation audits for 7 licensed nursing staff weekly for 4 weeks and monthly for 3 months. The audits will be 		

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F 880	<p>Continued From page 22</p> <p>The facility's undated Handwashing/Hand Hygiene policy, directed staff to use an alcohol-based hand rub containing 60-90% ethanol or isopropanol for all the following situations:</p> <ul style="list-style-type: none"> * Before preparing or handling medications, * After handling used dressings, contaminated equipment, etc., * After removing gloves. <p>The policy provided direction to apply the product to palm of hand and rub hands together and to cover all surfaces of hands and fingers until hands are dry at least 20 seconds.</p> <p>a. On 3/21/18 at 9:35 AM, LPN #2 was observed as she entered a resident room and turned the oxygen on for a resident residing in the room. LPN #2 came out of the room and pushed the medication cart down the hall to where Resident #49 was sitting. The LPN did not complete hand hygiene. LPN #2 then removed Resident #49's medications from the cart and began popping the medications in to a medication cup.</p> <p>LPN #2 then put gloves on and assisted Resident #49 with a multiple dose of a hand held inhaler. LPN #2 removed the gloves and threw them in the trash bin attached to the medication cart. The LPN returned to popping medications into a medication cup. She put gloves on and pulled 1 pill out of the medication cup, placed the pill in a pill cutter, and cut the pill in half. She put one half in the medication cup and threw the other half in to the sharps container attached to the medication cart. She removed the gloves and threw them in the trash bin.</p>	F 880	<p>reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/23/2018
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F 880	<p>Continued From page 23</p> <p>LPN #2 then poured a glass of water and directed Resident #49 to hold the glass of water as she placed the medications in his mouth using a spoon. When the resident had swallowed the medications, LPN #2 took the glass from the resident and threw it in the trash bin. No hand hygiene was completed by LPN #2.</p> <p>At 11:42 AM, LPN #2 prepared to complete a blood glucose test and provide insulin to Resident #10. LPN #2 washed her hands, put gloves on, and completed the blood glucose test. LPN #2 removed the gloves and threw them away. She then proceeded to document in the electronic record, got the supplies from the medication cart, withdrew insulin, and put gloves on. LPN #2 completed the insulin injection, disposed of the syringe in the sharps container, and removed the gloves. LPN #2 again put gloves on, cleaned the glucometer, removed the gloves and disposed of them in the trash bin attached to the medication cart. LPN #2 did not complete hand hygiene.</p> <p>On 3/21/18 at 2:55 PM, LPN #2 stated she would complete hand hygiene when her hands were contaminated, after every 3rd resident, and sanitize them if she did not complete handwashing. She said she would wash her hands after removing gloves and after she turned on a resident's oxygen. LPN #2 said she did not remember if she did hand hygiene or not. LPN #2 stated she did not remember if she washed her hands after removing her gloves.</p> <p>b. On 3/21/18 at 2:18 PM, LPN #1 was observed as she completed a dressing change for Resident #63. LPN #1 washed her hands and set</p>	F 880			

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

PRINTED: 04/20/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/23/2018
NAME OF PROVIDER OR SUPPLIER PARKE VIEW REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318		
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F 880	<p>Continued From page 24</p> <p>up a clean surface where she prepped the dressing, put saline on the 4x4 gauze pads, and put gloves on. LPN #1 then pulled the trash can closer to the bed, using her right gloved hand. She then used her right gloved hand to wring out the 4 x 4 dressing and clean the wound and surrounding area, without changing gloves. LPN #1 removed the gloves, washed her hands and put new gloves on to place the dressing.</p> <p>On 3/21/18 at 3:20 PM, LPN #1 stated she usually moved the trash can with her foot. LPN #1 stated she did not recall if she moved the trash can with her foot or hand during the observation. She said if she had recognized she moved it with her hand, she would have changed her gloves and washed her hands.</p> <p>On 3/21/18 at 4:50 PM, the Director of Nursing stated hand hygiene would be expected before and after resident care and after taking gloves off.</p>	F 880			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001580	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/23/2018
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NAME OF PROVIDER OR SUPPLIER PARKE VIEW REHABILITATION & CARE CENTI	STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318
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(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) COMPLETE DATE
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C 000	INITIAL COMMENTS The following deficiencies were cited during the state licensure survey conducted at the facility from March 19, 2018 through March 23, 2018. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Edith Cecil, RN Cecilia Stockdill, RN Wendi Gonzales, RN	C 000		
C 409	02.120,05,i Required Room Closet Space i. Closet space in each sleeping room shall be twenty inches by twenty-two inches (20" x 22") per patient/resident. Common closets utilized by two (2) or more patients/residents shall be provided with substantial dividers for separation of each patient's/resident's clothing for prevention of cross contamination. All closets shall be equipped with doors. Freestanding closets shall be deducted from the square footage in the sleeping room. This Rule is not met as evidenced by: Based on observation and resident and staff interview, it was determined 17 of 17 residents' room closets on the North Wing (Room #s 110, 112, 117, 118, 119, 120, 122, 124, 125, 126, 127, 128, 129, 130, 131, and 132), did not meet closet space requirements. Findings include: Observations and various random resident interviews during the initial tour on 3/19/18 revealed the unmet closet requirement did not	C 409	Parke View Rehabilitation & Care Center is requesting to continue the waiver for the closet space requirement on the North Wing.	4/20/18

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 04/13/18
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001580	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/23/2018
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NAME OF PROVIDER OR SUPPLIER PARKE VIEW REHABILITATION & CARE CENTI	STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318
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C 409	Continued From page 1 negatively impact resident's quality of life. On 3/19/18 at 11:00 AM, the Administrator said the facility would again request a waiver for the closet space requirement.	C 409		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

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November 6, 2018

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

Provider #: 135068

Dear Mr. Lewis, Jr.:

On **March 23, 2018**, an unannounced on-site complaint survey was conducted at **Parke View Rehabilitation & Care Center**. The complaint allegations, findings and conclusions are as follows:

Complaint or Entity-Report Incident #ID00007676

ALLEGATION #1:

Residents did not receive appropriate and timely incontinence care.

FINDINGS #1:

The clinical records of 19 resident records were reviewed for quality of care concerns. The facility's grievances were reviewed, as well as resident council minutes. Residents were observed for incontinence care.

Residents were interviewed regarding quality of care. Five of the residents interviewed stated they had no concerns with the care they received at the facility. Resident care was observed while in the facility and there were no concerns regarding inappropriate or timely care of those with incontinence.

The allegation was substantiated. The facility was not cited due to corrections and process improvements implemented by the facility.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #2:

Residents developed pressure ulcers while in the facility.

FINDINGS #2:

Residents were observed during wound care treatment, 19 resident records were reviewed, and there were pressure ulcer preventions in place observed.

The records of residents with wounds were reviewed. The records documented proper wound treatments were in place.

Residents said they received appropriate care to prevent pressure ulcers. CNAs and nurses said residents were receiving proper pressure ulcer prevention and/or treatment. The Wound Nurse said there was a resident whose skin issues were not pressure ulcers but redness and excoriation and were treated according to physician's orders.

The allegation could not be substantiated due to lack of evidence residents developed pressure ulcers while in the facility.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Residents received the wrong medication from what was ordered for treatment.

FINDINGS #3:

Medication error reports were reviewed, medication pass was observed, resident medication records were reviewed, and observations were made of nurses providing treatments. There were no medication error reports or incident reports regarding residents receiving the wrong treatment or medication from what was ordered by their physician.

One resident record documented he had excoriated skin to his left buttock. The resident's physician and family member were notified of the skin breakdown. The record documented the physician ordered barrier cream every shift and as needed until it was resolved. The record documented the barrier cream was applied as ordered.

Skin treatment of 3 residents was observed and the physician ordered medications were used by the nurses. The residents medication records were reviewed and included documentation the ordered treatments were administered.

The allegation was not substantiated due to lack of evidence residents received or were treated with the wrong medication during treatment.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Family members were not notified of laboratory results related to a urinary tract infection.

FINDINGS #4:

The records of 19 residents were reviewed for communication with resident family members. One resident's record documented she had a urinary tract infection and urine was sent to a laboratory for testing. The record did not document the family member was informed of the laboratory results after they were received.

The Assistant Director of Nursing said there was no documentation found which indicated the family member was informed of the lab results. The Wound Care Nurse was interviewed and she stated she was unable to find documentation the family member was notified of the results.

The allegation was substantiated. The facility was not cited because there was no change in the resident's status and no new course of treatment after the physician reviewed the laboratory results.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #5:

The facility did not provide records or updates to a resident's physician when they went out of the facility to a medical appointment.

FINDINGS #5:

Residents' records were reviewed and physician's visit communication progress notes were documented for medical appointments.

The Assistant Director of Nursing and the Transportation Coordinator said the physician's visit

communication progress notes were documented by facility staff, which included current concerns and a medication list for the residents. They said that the form was sent with the transportation CNA to medical appointments and the physician filled out the form and it was sent back to the facility. The transportation CNA said she took the communication forms back and forth when a resident was seen by an outside medical appointment.

The allegation could not be substantiated due to lack of evidence records and updates were not provided to the residents' physicians.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

Resident pain was not appropriately managed.

FINDINGS #6:

Nineteen resident records were reviewed for identification of pain and pain management. Residents were observed for pain control and no concerns were identified. Staff were observed to respond appropriately to residents' pain management and no concerns were identified. Nurses were observed to provide physician prescribed pain medication in a timely manner.

Residents said the facility staff managed their pain appropriately. Nurses were interviewed and said they monitored residents' pain and responded to them per physicians' orders.

The allegation could not be substantiated due to lack of evidence pain was not managed appropriately.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

Staff are rough while transferring residents and residents experience an increase of pain.

FINDINGS #7:

Several staff were observed to transfer several residents and residents did not complain of increased pain.

Grievances did not document staff had been rough while transferring residents. Several residents' records did not document rough treatment during transfers.

Several residents said they did not have concerns regarding staff being rough while being transferred. Several CNAs said they transferred residents appropriately and they would stop a transfer if a resident said or appeared to be in pain.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

Call lights were not answered in a timely manner.

FINDINGS #8:

Call lights and call light response times were observed during the survey and no concerns were identified.

Resident Council minutes were reviewed and did not include documentation call light response times were a concern. A resident meeting was held during the survey with 9 residents attending. The residents did not report issues or concerns related to call light response times by staff.

The allegation could not be substantiated due to lack of evidence call lights were not responded to in a timely manner.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #9:

Grievances were not addressed and investigated in a timely manner.

FINDINGS #9:

The facility's grievance records were reviewed and residents, the Administrator, and the Social Worker were interviewed.

The records documented grievances were investigated and addressed appropriately.

The Social Worker, who was also responsible for grievances, said the facility tried to resolve grievances as soon as possible, depending upon the type of grievance. The Social Worker said she received grievances

from floor staff, residents, or family members and they were presented to the Interdisciplinary Team and then to the Administrator for review and investigation.

The Administrator said the facility started investigating a grievance as soon as they received it, but it may take a few days to resolve the issues and get back with those who filed grievances due to the investigation phase of the concern. The Administrator stated after an investigation was completed they have spoken to those involved in person, as well as documenting the resolution in their grievance record.

Residents interviewed said concerns and grievances were followed up with in a timely manner.

The allegation could not be substantiated due to lack of evidence the facility did not investigate or address grievances.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #10:

Resident wheelchairs were not cleaned and had urine and feces in the seat.

FINDINGS #10:

Resident wheelchairs were observed for cleanliness throughout the survey and no concerns were identified. There were no grievances to the facility related to concerns about the cleanliness of wheelchairs.

A posted wheelchair cleaning schedule was observed at each nursing station.

Residents were interviewed and said they had no concerns with wheelchair or equipment cleanliness. CNAs said they would clean wheelchairs when they were dirty and also during the posted scheduled cleaning dates, which was kept at each nurses station. The Housekeeping Supervisor said CNA staff cleaned the wheelchairs when they were dirty and also during the posted scheduled cleaning dates, which was kept at each nurses station.

The allegation could not be substantiated due to lack of evidence wheelchairs were not cleaned.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Two of the allegations were substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Corwin Lewis, Jr., Administrator
November 6, 2018
Page 7 of 7

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in black ink, appearing to read "Laura Thompson". The signature is written in a cursive style and is positioned above the typed name.

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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January 31, 2019

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

Provider #: 135068

Dear Mr. Lewis, Jr.:

On **March 23, 2018**, an unannounced on-site complaint survey was conducted at Parke View Rehabilitation & Care Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007478

A Federal complaint investigation was conducted in conjunction with the facility's Federal recertification and state licensure survey, beginning March 19, 2018 through March 23, 2018.

Allegation #1: An identified resident's representative was not notified that the resident had started an antibiotic for a urinary tract infection.

Findings #1: During the investigation, staff were observed for interactions with residents. Medication administration was observed. The clinical record of the identified resident and several other residents' records were reviewed for quality of care concerns. The facility's abuse allegation reports and Grievance file were reviewed.

The identified resident and several other residents were interviewed regarding quality of care concerns. Several CNAs and nurses were interviewed regarding quality of care concerns. The Social Worker and the Director of Nursing were interviewed.

The identified resident's clinical record documented the resident's representative was informed of her prescribed antibiotic. Additionally, during interview, the identified resident stated they did not have any concerns regarding their medication changes.

Based on clinical record review and resident interview, it was determined the allegation could not be substantiated. Therefore, no deficiencies were cited due to lack of sufficient evidence.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: An identified resident developed a urinary tract infection and did not receive appropriate treatment, which led to a change of condition for the resident and the facility refused to send the resident to the hospital for evaluation.

Findings #2: The identified resident's clinical record was reviewed and no concerns were identified regarding infection treatment, change of medical condition, or further evaluation. Several other residents' records did not document concerns with treatments of infections or evaluations.

The identified resident stated they had no concerns regarding their infection treatment. The resident stated they did not want to go to the hospital for further evaluation because they received the care needed. Several other residents stated they received proper care. Several nurses stated residents received appropriate treatment for infections. The Director of Nursing stated the identified resident received proper care for their urinary tract infection and refused to go to the hospital for further evaluation.

Based on record review, resident and staff interview, it was determined the allegation could not be substantiated. Therefore, deficiencies were not cited due to lack of sufficient evidence.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: An identified resident was forced to change rooms due to an abusive nurse.

Findings #3: The facility's Grievance file did not document concerns regarding forced resident room moves. The identified resident's clinical record did not document a concern regarding forced room moves.

The identified resident stated they moved because a private room had become available and due to disagreements with a nurse on their former hall. The Director of Nursing stated the identified resident moved due to the availability of a private room.

Based on record review, resident and staff interview, it was determined the allegation could not be substantiated. Therefore, deficiencies were not cited due to lack of sufficient evidence.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: An identified resident was abused by an identified nurse who would not allow the resident to take medications with water and was verbally abusive toward the resident.

Findings #4: The identified nurse, and several other staff, were observed for interactions with residents and no concerns were identified. Several nurses were observed during medication administration and there were no concerns regarding medications given without water. The clinical record of the identified resident, and several other residents' records, did not document a concern regarding staff abuse. The facility's abuse-reportable incidents, did not document the identified nurse was abusive towards residents. The Grievance file documented a concern regarding a medication taken without water, but the identified resident stated they received water with their medications.

The identified resident stated they had a disagreement with a nurse, who worked on a different unit, but was not concerned about the situation. Several other residents stated staff were nice and appropriate with them. The facility Social Worker stated the facility took allegations and grievances seriously. Such allegations and grievances were thoroughly investigated to make sure residents were safe.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated. Therefore, deficiencies were not cited due to lack of significant evidence.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: An identified resident's hearing was not evaluated correctly and had been treated with ear drops unnecessarily, when the hearing issue was due to a faulty phone.

Findings #5: The clinical record of the identified resident documented appropriate treatment for their ear.

The identified resident stated they had been treated appropriately for hearing loss and wax build up. Several staff members stated the resident had hearing issues and had been treated appropriately. The Social Worker stated, in the past, there had been concerns with the resident's hearing and it was treated. The Social Worker also stated maintenance staff had serviced the resident's phone to see it was broken and determined there was a buildup of earwax in the phone's listening end. The resident's phone was subsequently cleaned.

Based on record review, resident and staff interview, it was determined the allegation could not be substantiated. Therefore, no deficiencies were cited due to lack of sufficient evidence.

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

Corwin Lewis, Jr., Administrator
January 31, 2019
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As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in black ink, appearing to read "Laura Thompson", is written over a light gray circular stamp.

LAURA THOMPSON, RN, Supervisor
Long Term Care Program

LT/pmt