



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RUSS BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR  
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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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June 5, 2018

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

Provider #: 135076

Dear . Gunderson:

On **May 18, 2018**, 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 a widespread 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 15, 2018**. Failure to submit an acceptable PoC by **June 15, 2018**, may result in the imposition of penalties by **June 7, 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 **June 22, 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 **August 16, 2018**. A change in the seriousness of the deficiencies on **July 2, 2018**, may result in a change

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in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 18, 2018** includes the following:

Denial of payment for new admissions effective **August 18, 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 **November 18, 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 **August 18, 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:

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

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

- BFS Letters (06/30/11)

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

This request must be received by **June 15, 2018**. If your request for informal dispute resolution is received after **June 15, 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/  
Enclosures

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

PRINTED: 06/27/2018  
FORM APPROVED  
OMB NO. 0938-0391

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>05/18/2018</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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted May 14, 2018 to May 18, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Linda Kelly, RN, Team Coordinator Presie Billington, RN Teresa Kobza, RD/LD Teri Hobson, RN</p> <p>Abbreviations:</p> <p>ADL = Activity of Daily Living cc = cubic centimeters CDC = Center for Disease Control CNA = Certified Nursing Assistants DNR = Do Not Resuscitate DON = Director of Nursing EMR = Electronic Medical Record I&amp;A = Incident and Accident IDT = Interdisciplinary Team LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set mg = milligram(s) RN = Registered Nurse ROM = Range of Motion</p>	F 000			
F 578 SS=D	<p>Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)</p> <p>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>§483.10(c)(8) Nothing in this paragraph should</p>	F 578		6/8/18	

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

TITLE

(X6) DATE

Electronically Signed

06/13/2018

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 578	<p>Continued From page 1</p> <p>be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.</p> <p>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).</p> <p>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the comprehensive care planning process included</p>	F 578	<p>Audit will be performed for every resident to ensure advance care directive is present and correct on each care plan.</p>		

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F 578	<p>Continued From page 2</p> <p>advance care directives, such as full code or Do Not Resuscitate (DNR), with re-evaluation on a routine basis and when there was a significant change in condition. This was true for 3 of 6 residents (#31, #186 and #187) whose advance directives were reviewed. The failure created the potential for harm if a resident's wishes were not followed due to lack of direction in their care plan. Findings include:</p> <p>1. Resident #31 was admitted to the facility on 3/15/18 with diagnoses which included right side hemiplegia related to cerebral infarction (stroke), dysphagia (difficulty swallowing), muscle weakness, and abnormal gait and mobility.</p> <p>A Resident/Family Consent for Cardiopulmonary Resuscitation documented Resident #31 chose the following option, "I understand that CPR [cardiopulmonary resuscitation] constitutes an extraordinary measure and should not be done on [resident's name]." The resident signed the form on 3/15/18.</p> <p>Resident #31's active physician orders documented a 4/1/18 order of DNR.</p> <p>Resident #31's comprehensive care plan did not document her advance care directive code status.</p> <p>On 5/18/18 at 10:50 AM, LPN #2 reviewed Resident #31's care plan and said Resident #31's code status was not in the care plan.</p> <p>On 5/18/18 at 10:55 AM, LPN #1 said Resident #31's code status was added to the care plan.</p>	F 578	<p>Will audit and update if necessary, advance care directives with quarterly and significant change of condition MDS assessments.</p> <p>Social services or designee will audit each resident's advance directive status weekly for 12 weeks. Staff development coordinator will educate social services and unit managers on how to pull the report for the weekly audit.</p> <p>The DON and ED will update the QA committee monthly for 3 months on findings. Further recommendations from the QA committee will be implemented.</p>		

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F 578	<p>Continued From page 3</p> <p>2. Resident #186 was admitted to the facility on 8/2/17 with diagnoses which included colon cancer, breast cancer, and colostomy.</p> <p>An admission MDS assessment, dated 8/9/17, documented Resident #186 was cognitively intact and was independent with most cares.</p> <p>The August 2017 Physician Orders documented Resident #186 was a full code, ordered 8/2/17.</p> <p>Resident #186's care plan did not include the resident's code status.</p> <p>On 5/16/18 at 2:50 PM, the DON stated he could not locate a code status in Resident #186's care plan.</p> <p>3. Resident #187 was readmitted to the facility 8/15/17 with diagnoses which included respiratory failure, acute kidney failure, and heart disease.</p> <p>A quarterly MDS assessment, dated 7/7/17, documented Resident #187 was cognitively intact and was dependent on staff with most cares.</p> <p>The July 2017 Physician Orders documented Resident #187's was DNR, ordered 10/14/16.</p> <p>An 8/1/17 Physician Progress note documented Resident #187 requested a change to a full code status.</p> <p>Resident #187's current care plan did not include her code status wishes.</p> <p>On 5/16/18 at 2:50 PM, the DON stated he could</p>	F 578			

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F 578	Continued From page 4 not locate a code status in Resident #187's care plan.	F 578			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.  §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.  §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, policy review, review of I&A reports, and record review, it was determined the facility failed to ensure residents were free from potential abuse. This was true for 1 of 1 resident (#82) reviewed for potential abuse. There was no investigation or assessment regarding two large bruises on Resident #82's left forearm, sustained during cares by staff. The deficient practice created the potential for Resident #82 to experience ongoing abuse/neglect without detection. Findings include:	F 610	On 5/16 bruising on resident #82 was assessed for size, treatment was put in place to monitor and resident was interviewed. As an intervention padding was added to bed rail. Family and MD were notified and care plan was updated and abuse was ruled out. SDC or designee will provide education to care staff on timely reporting of identified events to the administrator and a licensed nurse. Events of unknown origin will be investigated by the IDT. The licensed nurse will document the event in the	6/15/18	

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F 610	<p>Continued From page 5</p> <p>Resident #82 was admitted to the facility on 10/10/17 with multiple diagnoses including morbid obesity and that she was unable to voluntarily move her left side of her body following a stroke.</p> <p>The quarterly MDS assessment, dated 4/27/18, documented Resident #82 was cognitively intact. The MDS assessment documented Resident #82 required extensive assistance of 2 staff members with bed mobility. The MDS assessment documented Resident #82 had impaired mobility on one side.</p> <p>The facility's policy and procedure on abuse investigation, dated 11/28/17, documented:</p> <ul style="list-style-type: none"> <li>* All identified events are reported to the administrator immediately.</li> <li>* A licensed nurse will immediately examine the resident upon receiving reports of alleged physical or sexual abuse. The findings of the examination shall be recorded in the resident's medical record.</li> </ul> <p>On 5/14/18 at 3:58 PM, Resident #82 was observed with two dark purple bruises on her left upper forearm.</p> <p>On 5/14/18 at 3:59 PM, Resident #82 said she was pushed up against the bed rail during incontinence cares while in bed. She said she did not remember which CNAs provided the incontinence care or specifically when it occurred. Resident #82 stated she remembered she cried out in pain when it happened. She stated cares were rushed in the morning.</p>	F 610	<p>resident's medical record. SDC or designee will provide abuse training on facility policy and procedure, types of abuse, who to report to, screening for neglect, exploitation or mistreatment. Weekly audit by the IDT team as identified events arise. The DON and ED will update the QA committee monthly for 3 months on findings. Further recommendations from the QA committee will be implemented.</p>		

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F 610	<p>Continued From page 6</p> <p>The facility could not provide an incident report, investigation, care plan, or nursing notes for the bruises observed on Resident #82's left forearm on 5/14/18 at 3:58.</p> <p>On 5/22/18, the facility provided multiple skin observation sheets, dated 5/15/18 at 9:30 AM and 5/16/18 at 9:00 AM, that documented there were no bruises.</p> <p>On 5/16/18 at 3:33 PM, with LPN #5 present, Resident #82 again stated the bruises on her left forearm were caused by staff when she was turned in bed. Resident #82 stated she was pushed against the left rail of her bed during cares and called out in pain when it happened. She did not remember who was there when it occurred or when it happened. LPN #5 stated she had not seen the bruises previously.</p> <p>On 5/16/18 at 3:40 PM, CNA #5 stated he was not aware of when Resident #82 was injured. He stated he saw the bruises and did not report them because they were there when he came to work on the hall Resident #82 resided on.</p> <p>On 5/16/18 at 3:44 PM, the DON stated he was not aware that an injury had occurred with Resident #82. The DON stated there was no documentation regarding bruising in Resident #82's record and he was not aware of the incident.</p> <p>On 5/16/18 at 3:52 PM, LPN #5 said Resident #82's family stated they saw the bruises over the weekend and did not mention the bruises to facility staff. LPN #5 stated she provided teaching regarding the need to alert staff of changes they</p>	F 610			

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F 610	Continued From page 7 observe during visits.	F 610			
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)  §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or	F 622		6/15/18	

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F 622	<p>Continued From page 8</p> <p>discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.</p> <p>§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(i) Documentation in the resident's medical record must include:</p> <p>(A) The basis for the transfer per paragraph (c) (1)(i) of this section.</p> <p>(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).</p> <p>(ii) The documentation required by paragraph (c) (2)(i) of this section must be made by-</p> <p>(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and</p> <p>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.</p> <p>(iii) Information provided to the receiving provider must include a minimum of the following:</p> <p>(A) Contact information of the practitioner responsible for the care of the resident.</p> <p>(B) Resident representative information including</p>	F 622			

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F 622	<p>Continued From page 9 contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure transfer information was provided to the receiving hospital for emergent situation for 2 of 5 residents (#18 and #186) reviewed for transfer. This deficient practice had the potential to cause harm if the resident was not treated in a timely manner due to a lack of information. Findings include:</p> <p>1. Resident #18 was admitted to the facility on 5/24/17 and readmitted on 5/2/18 with diagnoses which included Parkinson's disease and heart failure.</p> <p>A quarterly MDS assessment, dated 5/9/18, documented Resident #18's cognition was intact and she needed extensive assistance with most ADLs.</p> <p>Nursing Progress Notes, dated 4/28/18, documented the following:</p> <p>* 10:33 AM - Resident began vomiting at approximately 7:00 AM, went back to bed to rest, and drank fluids but did not eat anything solid.</p>	F 622	<p>All LN staff will be educated that verbal report will be given to the receiving facility, and that the information provided to the receiving facility will be documented in the specific patient's medical record.</p> <p>Education will be completed by 06/15/2018.</p> <p>The audit will be performed weekly by DON or designee for 12 weeks. The DON and ED will update the QA committee monthly for 3 months on findings. Further recommendations from the QA committee will be implemented.</p>		

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F 622	<p>Continued From page 10</p> <p>* 3:16 PM - Resident continued to vomit, was diaphoretic (sweating heavily), febrile (feverish), hypertensive (high blood pressure), tachycardic (rapid heart rate), oxygen saturation was 99%, the physician was notified and recommended the resident be sent to the hospital emergency room.</p> <p>* 4:21 PM - Resident was sent to an emergency room with paramedics.</p> <p>* 10:50 PM - Resident was admitted to a hospital for acute encephalopathy (disorder or disease of the brain).</p> <p>There was no documentation that information about Resident #18, or the events that lead up to her transfer to the emergency room on 4/28/18, were conveyed to the paramedics who transported the resident or to the emergency department.</p> <p>On 5/17/18 at 3:00 PM, the DON said there was no specific policy for urgent/emergent transfers. The DON said the nurse would send the resident's face sheet, diagnoses, medication list, advance directive, and vital signs, and give a verbal report to EMTs but there was no record of what was actually sent.</p> <p>2. Resident #186 was admitted to the facility on 8/2/17 with diagnoses which included colon cancer, breast cancer, and colostomy. The resident was transferred to a hospital on 8/22/17.</p> <p>An admission MDS assessment, dated 8/9/17, documented Resident #186 was cognitively intact and was independent with most cares.</p>	F 622			

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F 622	Continued From page 11  A Progress Note, dated 8/22/17, documented Resident #186 complained of nausea in her sternal area (bone in the center of the chest). The note documented Resident #186 had bowel tones in all four quadrants and her ostomy (opening in her colon) had green brown liquid stool. The note documented Resident #186 was not experiencing emesis (vomiting) and she declined pain medicine, anti-emetic medicine, and food and fluids. The note documented a nurse practitioner assessed Resident #186 and offered to send her to the hospital. The note documented Resident #186 agreed to the hospital transfer. The note documented Resident #186 was transferred to the hospital.  Resident #186's record did not include documentation of transfer information sent to the hospital.  On 5/16/18 at 2:50 PM, the DON stated when a resident was sent emergently to the hospital the facility sent a packet of information to the receiving facility. The DON stated they provided the resident's face sheet, vital signs, advanced directive information, physician orders, and a nursing progress note, if it was documented before the resident left the facility.  Documentation of transfer information for Resident #186 being sent to the hospital was not provided by the facility.	F 622			
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii)  §483.20 Resident Assessment The facility must conduct initially and periodically	F 636		6/26/18	

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F 636	Continued From page 12 a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.	F 636			

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F 636	Continued From page 13  §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii) Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and record review, it was determined the facility failed to ensure residents' beds positioned against a wall were assessed as potential restraints. This was true for 6 of 6 (#41, #45, #54, #68, #77, & #82) residents sampled for potential restraints. This deficient practice placed the residents at risk of having their beds placed against a wall as a method of restraint without assessment of the need and safety of the restraint. Findings include:  1. Resident #82 was admitted to the facility on 10/10/17 with diagnoses which included morbid obesity, she was unable to voluntarily move her left side of her body following a stroke.  The quarterly MDS assessment, dated 4/27/18, documented Resident #82 was cognitively intact.	F 636	DON or designee will audit all beds in the facility and identify all beds positioned against a wall by 6/15/18. Each resident with a bed against a wall will be educated on the potential risk. DON or designee will complete a restraint enabling device assessment for each resident with their bed against the wall by 06/18/2018. A consent form will be completed and care plan will reflect bed position in the room by 06/18/2018. SDC or designee will educate staff on beds against the wall as a potential restraint. If a bed needs to be moved away from the wall the IDT team will be notified. IDT will complete education to the resident, the assessment and consent will be completed, and care plan will be updated. Education will be complete by		

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F 636	<p>Continued From page 14</p> <p>The MDS assessment documented Resident #82 required extensive assistance of two staff members with bed mobility. The MDS assessment documented Resident #82 had impaired mobility on one side.</p> <p>On 5/14/18 at 3:58 PM, Resident #82's bed was observed against the wall. At that time, Resident #82 stated she had no idea why her bed was against the wall.</p> <p>On 5/16/18 at 4:44 PM, the DON stated he knew Resident #82's bed was against the wall. The DON stated there was no documentation of assessment of the bed against the wall as a potential restraint.</p> <p>2. Resident #41 was admitted to the facility on 12/18/17 with diagnoses which included cerebral palsy, contractures of multiple joints, and pressure ulcers.</p> <p>A quarterly MDS assessment, dated 3/29/18, documented Resident #41 was cognitively intact and required extensive assistance of 2 staff members with bed mobility.</p> <p>On 5/14/18 at 10:10 AM, Resident #41's bed was observed positioned against the wall.</p> <p>Resident #41's clinical record did not include an assessment of her bed against the wall as a possible restraint.</p> <p>On 5/17/18 at 6:18 PM, LPN #3 stated Resident #41 wanted the bed against the wall due to a fear of falling. LPN #3 stated the facility had not assessed residents' beds against the walls as</p>	F 636	<p>6/26.</p> <p>DON or designee will complete initial audit of entire facility. Plant manager or designee will complete weekly audits for positioning of the bed in the room for 12 weeks. The DON and ED will update the QA committee monthly for 3 months on findings. Further recommendations from the QA committee will be implemented.</p>		

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F 636	<p>Continued From page 15</p> <p>potential restraints because they did not consider them restraints.</p> <p>3. Resident #77 was readmitted to the facility on 4/23/18 with diagnoses which included muscle weakness, limitation of activity, and abnormalities of gait and mobility.</p> <p>An admission MDS assessment, dated 4/30/18, documented Resident #77 was cognitively intact and required extensive assistance of 2 staff members with bed mobility.</p> <p>On 5/14/18 at 11:40 AM, Resident #77's bed was observed positioned against the wall.</p> <p>Resident #77's clinical record did not include an assessment of his bed against the wall as a possible restraint.</p> <p>On 5/16/18 at 4:30 PM, the DON stated he was aware residents' beds were positioned against the wall. The DON stated he was not aware beds positioned against the wall was a potential restraint and stated the facility had not completed assessments.</p> <p>4. Resident #68 was admitted to the facility on 5/1/15 with multiple diagnoses, including dementia with behavioral disturbances and generalized muscle weakness.</p> <p>Resident #68's annual MDS assessment, dated 4/19/18, documented she was severely cognitively impaired, required assistance of two staff members for bed mobility, transfer and toilet use.</p>	F 636			

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F 636	<p>Continued From page 16</p> <p>On 5/16/18 at 10:38 AM and 3:19 PM, and on 5/17/18 at 11:55 AM and 12:40 PM, Resident #68 was observed in her bed with her bed positioned against the wall.</p> <p>Resident #68's clinical record did not include an assessment of her bed against the wall as a possible restraint.</p> <p>On 5/16/18 at 4:30 PM, the DON stated he was not aware beds positioned against the wall was a potential restraint and the facility had not completed assessments.</p> <p>5. Resident #45 was admitted to the facility on 7/7/17 with multiple diagnoses, including cellulitis (bacterial skin infection) of right lower leg.</p> <p>Resident #45's quarterly MDS assessment, dated 3/30/18, documented she was cognitively intact and required the assistance of one staff for bed mobility and transfer.</p> <p>On 5/14/17 at 12:49 PM and on 5/18/18 at 9:14 AM, Resident #45's bed was observed positioned against the wall.</p> <p>Resident #45's clinical record did not include an assessment of her bed against the wall as a possible restraint.</p> <p>On 5/16/18 at 4:30 PM, the DON stated the facility had not completed assessments of beds against the wall as potential restraints.</p> <p>6. Resident #54 was admitted to the facility on 12/29/17 with multiple diagnoses, including stress fracture of the right humerus (bone of the</p>	F 636			

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F 636	Continued From page 17 upper arm) and generalized muscle weakness.  Resident #54's quarterly MDS assessment, dated 4/10/18, documented she was moderately cognitively impaired, and required the assistance of two staff members for bed mobility, transfer and dressing.  On 5/14/18 at 3:30 PM and 4:24 PM, Resident #54 was in bed sleeping, with her bed against the wall.  Resident #54's clinical record did not include an assessment of her bed against the wall as a possible restraint.  On 5/17/17 at 6:06 PM, LPN #1 said the residents' beds were positioned against the wall to give them more space in their rooms. LPN #1 said the facility did not assess the residents' beds against the wall as possible restraints because they did not consider a bed against the wall as a potential restraint.	F 636			
F 655 SS=E	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		6/15/18	

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F 655	<p>Continued From page 18</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 resident and staff interview, it was determined the facility failed to ensure residents and their representatives, if applicable, received a written summary of the baseline care plan. This was true for 4 of 8 residents (#16, #29, #31, and #49) whose</p>	F 655	<p>DON or designee will complete baseline care plan within 48 hours of the admit, and social services director or designee will provide a copy of the baseline care plan to the resident or resident representative.</p>		

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F 655	<p>Continued From page 19</p> <p>baseline care plans were reviewed. The failure created the potential for harm when residents and their representatives were not included in planning the resident's care. Findings include:</p> <p>1. Resident #29 was originally admitted to the facility on 11/4/17 with diagnoses which included general muscle weakness, abnormal gait/mobility, and dementia. The resident was discharged to a community setting on 11/17/17. Seventeen days later, on 12/4/17, the resident was readmitted to the facility from a hospital with new diagnoses, including right hip fracture &amp; fractures of two fingers on the right hand.</p> <p>A admission MDS assessment, dated 12/11/17, documented Resident #29's cognition was moderately impaired, she was usually understood by others and usually able to understand others, and she and her legal representative participated in the assessment and goal setting.</p> <p>Resident #29's current care plan included problem areas and interventions created during her first stay in the facility (11/4/17 to 11/17/17) which were revised and initiated on 12/4/17 when she returned to the facility. The care plan areas revised and initiated on 12/4/17 included the potential for skin impairment, self care deficit, activities, risk for falls, potential for nutritional problems, and pain related to a history of hip and lumbar fractures.</p> <p>There was no documented evidence in Resident #29's clinical record that a written summary of the baseline care plan was given to the resident or her representative.</p>	F 655	<p>Medical records will audit signed baseline care plans are in place two times per week for 12 weeks. The DON and ED will update the QA committee monthly for 3 months on findings. Further recommendations from the QA committee will be implemented.</p>		

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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) COMPLETION DATE	
F 655	<p>Continued From page 20</p> <p>On 5/18/18 at 11:40 AM, the DON, said he did not find documentation that a summary of the baseline care plan was given to Resident #29 or her representative.</p> <p>2. Resident #31 was admitted to the facility on 3/15/18 with diagnoses which included right side hemiplegia related to cerebral infarction (stroke), dysphagia (difficulty swallowing), muscle weakness, and abnormal gait and mobility.</p> <p>The admission MDS assessment, dated 3/22/18, documented Resident #31's cognition was intact, she was understood by others and able to understand others, and she participated in the assessment and goal setting.</p> <p>On 5/18/18 at 10:15 AM, LPN #1 provided an Initial Care Plan, which she said was Resident #31's baseline care plan. The baseline care plan was signed by a nurse on 3/15/18. LPN #1 said there was no documentation that a baseline care plan summary was given to the resident.</p> <p>On 5/18/18 at 10:26 AM, Resident #31 said the facility did not review the plan for her care or give her "papers" within the first few days after she was admitted to the facility.</p> <p>3. Resident #49 was originally admitted to the facility on 12/24/17 with multiple diagnoses which included left hip traumatic arthropathy (condition or disease of a joint), muscle weakness, abnormal gait, chronic pain syndrome, and Alzheimer's disease. The resident was discharged to an assisted living facility on 1/24/18. Sixteen days later, on 2/9/18, she was</p>	F 655			

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F 655	<p>Continued From page 21</p> <p>readmitted to the facility with the same diagnoses.</p> <p>An admission MDS assessment, dated 12/30/17, documented Resident #49's cognition was moderately impaired, she was usually understood by others and was usually able to understand others, and she and her family or significant other participated in the assessment and goal planning.</p> <p>An admission MDS assessment, dated 2/16/18, documented Resident #49's cognition was moderately impaired, she was usually understood by others and was usually able to understand others, and she and her legal guardian or legal representative participated in the assessment and goal planning.</p> <p>On 5/17/18 at 6:15 PM, LPN #1 provided an Initial Care Plan, dated 12/24/17, which she said was Resident #49's baseline care plan for the 12/24/17 admission and the baseline care plan for the 2/9/18 admission was integrated into the comprehensive care plan. LPN #1 said the baseline care plans were not given to Resident #49 or her representative.</p> <p>4. Resident #16 was admitted to the facility on 2/13/18, with diagnoses which included cancer of the small intestine, intestinal obstruction, anxiety, and pain.</p> <p>A admission MDS assessment, dated 2/20/18, documented Resident #16's cognition was severely impaired, she was understood by others, she was able to understand others, and she participated in the assessment and goal</p>	F 655			

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F 655	Continued From page 22 setting.	F 655			
F 656 SS=E	<p>On 5/17/18 at 6:15 PM, LPN #1 provided an Initial Care Plan, dated 2/14/18, which she said was Resident #16's baseline care plan. LPN #1 said Resident #16's baseline care plan was not given to the resident or her representative.</p> <p>Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)</p> <p>§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 -</p> <p>(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</p> <p>(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).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR 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>	F 656		6/18/18	

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F 656	<p>Continued From page 23</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: Based on observation, record review, policy review, and staff interview, it was determined the facility failed to develop and implement comprehensive, resident centered care plans. This was true for 6 of 18 sampled residents (#18, #41, #45, #54, #68, and #77) whose care plans were reviewed. The residents' care plans did not address the bed positioned against the wall as a possible restraint, and the setting for the use of a CPAP (Continuous Positive Airway Pressure) machine, which created the potential for residents to receive inappropriate or inadequate care with subsequent decline in health. Findings include:</p> <p>1. Resident #68 was admitted to the facility on 5/1/15 with multiple diagnoses, including dementia with behavioral disturbances and generalized muscle weakness.</p> <p>Resident #68's annual MDS assessment, dated 4/19/18, documented she was severely cognitively impaired, and required assistance of two staff members for bed mobility, transfer and</p>	F 656	<p>IDT will meet Monday-Friday and will review care plans and revise care plans as needed.</p> <p>MDS resource will create education and SDC or designee will provide education to LN staff by 06/15/2018.</p> <p>All care plans will be audited for revisions by 06/15/2018.</p> <p>Audits will be completed Monday-Friday by the IDT for 12 weeks. The DON and ED will update the QA committee monthly for 3 months on findings. Further recommendations from the QA committee will be implemented.</p>		

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F 656	<p>Continued From page 24 toilet use.</p> <p>On 5/16/18 at 10:38 AM and 3:19 PM, and on 5/17/18 at 11:55 AM and 12:40 PM, Resident #68 was observed in her bed with her bed positioned against the wall.</p> <p>Resident #68's care plan did not address the positioning of her bed against the wall.</p> <p>On 5/16/18 at 4:30 PM, the DON stated he was not aware a bed positioned against the wall was a potential restraint and the facility did not include them in resident care plans.</p> <p>2. Resident #45 was admitted to the facility on 7/7/17 with multiple diagnoses, including cellulitis (bacterial skin infection) of right lower leg.</p> <p>Resident #45's quarterly MDS assessment, dated 3/30/18, documented she was cognitively intact and required the assistance of one staff member for bed mobility and transfer.</p> <p>On 5/14/17 at 12:49 PM and on 5/18/18 at 9:14 AM, Resident #45's bed was observed positioned against the wall.</p> <p>Resident #45's care plan did not document her bed was positioned against the wall.</p> <p>On 5/16/18 at 4:30 PM, the DON stated he was not aware a bed positioned against the wall was a potential restraint and the facility did not include them in resident care plans.</p> <p>3. Resident #54 was admitted to the facility on 12/29/17 with multiple diagnoses, including</p>	F 656			

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F 656	<p>Continued From page 25</p> <p>stress fracture of the right humerus (bone of the upper arm) and generalized muscle weakness.</p> <p>Resident #54's quarterly MDS assessment, dated 4/10/18, documented she was moderately cognitively impaired, and required an assistance two staff members for bed mobility, transfer and dressing.</p> <p>On 5/14/18 at 3:30 PM and 4:24 PM, Resident #54 was in bed sleeping, with her bed against the wall.</p> <p>Resident #54's care plan did not document her bed was positioned against the wall.</p> <p>On 5/17/17 at 6:06 PM, LPN #1 said the residents' bed were positioned against the wall to give them more space in their room. The LPN said the facility did not included bed against the wall in the residents' care plan because they did not consider bed against the wall as a potential restraint.</p> <p>4. Resident #41 was admitted to the facility on 12/18/17 with diagnoses which included cerebral palsy, contractures of multiple joints, and pressure ulcers.</p> <p>A quarterly MDS assessment, dated 3/29/18, documented Resident #41 was cognitively intact and required extensive assistance of 2 staff members with bed mobility.</p> <p>On 5/14/18 at 10:10 AM, Resident #41's bed was observed positioned against the wall.</p> <p>Resident #41's care plan did not document her</p>	F 656			

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F 656	<p>Continued From page 26 bed was positioned against the wall.</p> <p>On 5/17/18 at 6:18 PM, LPN #3 stated the resident wanted the bed against the wall due to a fear of falling. LPN #3 stated the facility had not documented Resident #41's bed position in the care plan.</p> <p>5. Resident #77 was readmitted to the facility on 4/23/18 with diagnoses which included muscle weakness, limitation of activity, and abnormalities of gait and mobility.</p> <p>An admission MDS assessment, dated 4/30/18, documented Resident #77 was cognitively intact and required extensive assistance of 2 staff members with bed mobility.</p> <p>On 5/14/18 at 11:40 AM, Resident #77's bed was observed positioned against the wall.</p> <p>Resident #77's care plan did not document his bed was positioned against the wall.</p> <p>On 5/16/18 at 4:30 PM, DON stated he was aware residents' beds were positioned against the wall. The DON stated beds positioned against the wall were not included in residents' care plans.</p> <p>6. Resident #18 was admitted to the facility on 5/24/17 and readmitted on 5/2/18 with diagnoses which included Parkinson's disease and heart failure.</p> <p>A quarterly MDS assessment, dated 5/9/18, documented Resident #18's cognition was intact; she needed extensive assistance with most</p>	F 656			

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F 656	Continued From page 27 ADLs; and section O, regarding respiratory treatments, was blank.  Resident #18's current care plan included altered respiratory status/difficulty breathing related to "Sleep Apnea" on 3/12/18. One interventions was, "Provide CPAP [continuous positive airway pressure] as ordered." It was initiated on 3/12/18.  Resident #18's active orders for 3/1/18 to 5/31/18 included a 5/2/18 order for "CPAP per settings every night shift."  On 5/14/18 at 11:33 AM and through out the survey, a CPAP machine and mask were observed on Resident #18's bedside table.  On 5/17/18 at 6:20 PM, when asked what the care plan was for Resident #18's CPAP, LPN #2 reviewed the resident's care plan, then the CPAP order, then said the setting for CPAP was not documented.  On 5/17/18 at 7:30 PM, RN #6 said she applied Resident #18's CPAP at night. When asked what the care plan was for the CPAP settings, RN #6 reviewed the resident's care plan, then the CPAP order, then said the setting for the CPAP was not documented.  On 5/21/18 at 4:35 PM, the facility faxed Resident #18's order, dated 11/21/17, for "CPAP PS [pressure setting] 12" for obstructive sleep apnea.	F 656			
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)  §483.21(b) Comprehensive Care Plans	F 657		6/18/18	

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F 657	<p>Continued From page 28</p> <p>§483.21(b)(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(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.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure care plans were revised as residents' needs changed. This was true for 4 of 18 residents (#3, #41, #77, and #187) whose care plans were reviewed. The failure created the potential for harm when:</p> <p>* Resident #3's care plan was not revised when his dialysis access device was changed.</p> <p>* Resident #41's care plan was not revised to</p>	F 657	<p>IDT will meet Monday-Friday and will review physician orders, care plans, revisions, alerts and revise care plans as needed.</p> <p>MDS resource will create education and SDC or designee will provide education to LN staff by 06/15/2018.</p> <p>All care plans will be audited for revisions by 06/15/2018.</p> <p>Audits will be completed Monday-Friday</p>		

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F 657	<p>Continued From page 29</p> <p>include all of her specific signs and symptoms of depression.</p> <p>* Resident #77's care plan was not revised after he was removed from isolation precautions after active C-diff (a serious infection of the colon that causes severe diarrhea).</p> <p>* Resident 187's family was not a part of the comprehensive care planning process.</p> <p>Findings include:</p> <p>1. Resident #187 was readmitted to the facility 8/15/17 with diagnoses which included respiratory failure, acute kidney failure, and heart disease.</p> <p>A quarterly MDS assessment, dated 7/7/17, documented Resident #187 was cognitively intact and was dependent on staff with most cares.</p> <p>a. An IDT approach was not utilized during Resident #187's comprehensive care planning process as follows:</p> <p>A Progress Note, dated 7/18/17, documented a care conference was held for Resident #187 and social services and a CNA were present at the meeting. The note documented the resident was invited to attend and no other parties were invited.</p> <p>On 5/17/18 at 1:50 PM, the Social Services Director and Licensed Social Worker (LSW) stated letters were sent out to residents' family members a week in advance of a care conferences inviting them to attend. The Social Services Director and LSW were unable to provide documentation of when or who a letter</p>	F 657	<p>by the IDT for 12 weeks. The DON and ED will update the QA committee monthly for 3 months on findings. Further recommendations from the QA committee will be implemented.</p>		

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F 657	<p>Continued From page 30 was sent to regarding Resident #187's 7/18/17 care conference meeting.</p> <p>b. A care plan conference was not held after Resident #187 was readmitted from the hospital as follows:</p> <p>Resident #187's clinical record did not contain a care plan conference dated after her readmission of 8/15/17.</p> <p>On 5/17/18 at 1:50 PM, the Social Services Director stated a care conference would occur 24 - 48 hours after readmission from a hospital stay. The Social Services Director stated she did not know why this did not occur after Resident #187 was readmitted on 8/15/17.</p> <p>2. Resident #41 was admitted to the facility on 12/18/17 with diagnoses which included depression.</p> <p>A quarterly MDS assessment, dated 3/29/18, documented Resident #41 was cognitively intact and had minimal signs and symptoms of depression.</p> <p>Resident #41's care plan, dated 3/29/18, documented she was at risk for depression and anxiety and refused cares at times. The care plan documented Resident #41 would remain free of signs and symptoms of distress, symptoms of depression, anxiety, or sad mood through the review date.</p> <p>Resident #41's MAR, dated 5/1/18 through 5/17/18, documented depression presented as crying, sad worried facial expressions, and</p>	F 657			

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F 657	<p>Continued From page 31 voicing depression.</p> <p>On 5/18/18 at 10:00 AM, the LSW stated Resident #41's symptom of depression was occasionally refusal of cares. The LSW stated Resident #41 previously refused care often and now she did not refuse care as often. The LSW stated the facility monitored the refusals in nursing progress notes. The LSW stated Resident #41's main sign and symptom of depression listed on the care plan was sad mood.</p> <p>On 5/18/18 at 10:15 AM, the Social Services Director stated Resident #41's depression signs and symptoms on the MAR did not match the care plan.</p> <p>3. Resident #77 was readmitted to the facility on 4/23/18 with diagnoses which included colitis and C-diff.</p> <p>An admission MDS assessment, dated 4/30/18, documented Resident #77 was cognitively intact.</p> <p>Resident #77's care plan, dated 4/23/18, documented he had active C-diff on admission from the hospital. C-diff is contagious and can be spread from person-to-person by touch or by direct contact with contaminated objects and surfaces. Isolation and contact precautions are necessary to avoid the spread of the infection to others.</p> <p>Resident #77's discharge instructions from the hospital, dated 4/23/18, documented he did not require isolation.</p>	F 657			

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

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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>05/18/2018</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>		
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F 657	<p>Continued From page 32</p> <p>On 5/14/18 at 11:40 AM, Resident #77 was observed in a recliner chair with staff entering the room and there were no isolation precautions present at the entrance of the door or notifications.</p> <p>On 5/18/18 at 1:20 PM, the DON stated the care plan should not have documented Resident #77 had active C-diff.</p> <p>On 5/18/18 at 1:20 PM, LPN #1 stated Resident #77 was having formed stools while in the hospital and the hospital did not have him on contact precautions. The Nurse Manager said Resident #77 was not placed on precautions at the facility upon admission.</p> <p>4. Resident #3 was admitted to facility on 2/21/17, with diagnoses which included end stage renal disease and a dependence on dialysis.</p> <p>An annual MDS assessment, dated 5/3/18, documented Resident #3 was cognitively intact.</p> <p>A Nursing Progress Note, dated 4/28/18, documented Resident #3 had a newly placed central venous catheter (CVC) to right chest for hemodialysis.</p> <p>Resident #3's care plan, initiated on 5/9/18, documented staff were to assess his fistula daily. The care plan was not updated when the dialysis access site was changed from a fistula to a CVC on 4/28/18. The facility obtained an order to assess Resident #3's CVC to right upper chest daily until discontinued, on 5/14/18.</p>	F 657			

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F 657	Continued From page 33 On 5/16/18 at 2:11 PM, the DON stated Resident #3's care plan was not updated to reflect the CVC prior to 5/14/18. The DON stated the facility did not have a strict policy when to revise a care plan.	F 657			
F 684 SS=D	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure residents received assessments and care in accordance with professional standards of practice. This was true for 1 of 4 (#33) residents reviewed who were prescribed blood pressure medications. Resident #33 had the potential for harm from low blood pressure or high heart rate when blood pressure medications were administered without consistently monitoring blood pressures and heart rates as ordered. Findings include:  1. Resident #33 was admitted to facility 2/14/2017 with diagnoses which included dementia, chronic atrial fibrillation, coronary artery disease (CAD) and essential (primary) hypertension.  A significant change MDS assessment, dated	F 684	Blood pressure and pulse order reviewed and updated for patient #33. IDT will meet Monday-Friday and will review all physician orders auditing that orders are transcribed correctly.  Staff were educated on the requirement to complete all MD ordered vital signs.  DON or designee will audit each shift three times per week, reviewing that MD ordered vitals are obtained and entered into the EHR.  SDC or designee will educate LN staff on order entry processing for monitoring of pulse and blood pressure.  IDT will audit weekly for 12 weeks. The	6/15/18	

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F 684	Continued From page 34 3/23/18, documented Resident #33 was severely cognitively impaired.  Resident #33's May 2018 active physician orders included the following:  *Resident #33's blood pressure and heart rate were to be checked every day shift, ordered 3/19/18. *Amlodipine Besylate tablet 10 mg one time a day for hypertension *Metoprolol tablet 25 mg two times a day for hypertension  Resident #33's care plan, dated 3/30/18, for hypertension documented she was to be given anti-hypertensive medications as ordered and be monitored for orthostatic hypotension (low blood pressure), increased heart rate (tachycardia), and the effectiveness of the medication.  Resident #33's record did not include documentation her heart rate and blood pressure were assessed between 3/22/18 and 4/4/18, 4/6/18 and 4/10/18, 4/11/18 and 4/20/18, and 4/21/18 and 5/1/18.  On 5/17/18 at 12:00 PM, the DON said if an order to check blood pressure and heart rate was active, the checks would have been done.	F 684	DON and ED will update the QA committee monthly for 3 months on findings. Further recommendations from the QA committee will be implemented. Vital signs obtained and completed per MD order. Audit will be completed 3 times per week that required vitals are completed per MD order.		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		6/15/18	

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F 689	<p>Continued From page 35</p> <p>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of I&amp;A reports and resident records, it was determined the facility failed to ensure residents received the level of supervision necessary to prevent falls and elopement from the facility. This was true for 1 of 1 (#33) resident reviewed for supervision. Resident #33 had the potential for harm when the facility failed to provide her with the necessary supervision and assistive devices while walking through the facility and outside. Findings include:</p> <p>Resident #33 was admitted to facility on 2/14/17 with diagnoses which included traumatic brain hemorrhage, dementia, muscle weakness, history of falls, Alzheimer's Disease, and cognitive communication deficit.</p> <p>A significant change MDS assessment, dated 3/23/18, documented Resident #33 was severely cognitively impaired. The MDS assessment documented Resident #33 required extensive assistance of 1 to 2 staff members with bed mobility, transfers, and locomotion on and off the unit.</p> <p>An Initial Nursing Assessment, dated 4/14/18, documented Resident #33 was not ambulatory or self-mobile in her wheelchair. The assessment documented "(If yes, an Elopement/Wandering Evaluation will be triggered)."</p> <p>Resident #33's current care plan documented</p>	F 689	<p>DON or designee will review and update Resident #33's care plan and ensure the elopement portion of the care plan is current and level of supervision is appropriate by 06/15/2018.</p> <p>DON or designee will also review and update care plan for all residents with potential for elopement by 06/15/2018.</p> <p>SDC or designee will educate staff on how to access information on the care plan on level of supervision for each patient to help prevent falls. Therapy will provide written education to the staff communication board when a level of supervision is altered for a patient. IDT will receive notification and update care plan.</p> <p>Facility fall protocol updated to start Q 15 minute checks for individuals who have a fall, and this will last for at least 24 hours.</p> <p>DON or designee will review residents weekly for elopement and update care plans. The DON and ED will update the QA committee monthly for 3 months on findings. Further recommendations from the QA committee will be implemented.</p>		

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F 689	<p>Continued From page 36</p> <p>she had a wander guard to prevent elopement. Resident #33's care plan documented she required 1-2 staff members assistance with cares including bed mobility, transfers, and locomotion.</p> <p>Resident #33's I&amp;A Reports documented she experienced three falls and eloped from the facility one time, as follows:</p> <ul style="list-style-type: none"> <li>* On 9/9/17 Resident #33 eloped from the facility and was returned within 15 minutes of front door alarm reset, by the local police department, without injury.</li> <li>* On 2/28/18 Resident #33 experienced a fall and stated she might have hit her head.</li> <li>* On 4/3/18 and 4/9/18 Resident #33 experienced a fall in the dining room.</li> </ul> <p>Resident #33 was observed without supervision, assistive devices, and wander guard, as follows:</p> <ul style="list-style-type: none"> <li>* On 5/14/18 at 4:40 PM, Resident #33 was sitting on the edge of her bed reaching for her shoes on the floor. Her forehead was close to touching the floor. No staff members were present and she was calling out for help.</li> <li>* On 5/14/18 at 4:51 PM, a surveyor asked CNA #3 to assist Resident #33. CNA #3 assisted Resident #33 to bed and removed her shoes from her hands. CNA #3 stated Resident #33 should not be up without staff assistance. CNA #3 left Resident #33's room.</li> <li>* On 5/14/18 at 5:05 PM, Resident #33 was raising herself to a sitting position on the edge of</li> </ul>	F 689			

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F 689	<p>Continued From page 37</p> <p>her bed and began rocking back and forth.</p> <p>* On 5/14/18 at 5:19 PM, Resident #33 stood from her bed and walked toward her bedroom door while in her stocking feet. Resident #33 was not using a cane or a wheelchair to assist her while walking. No staff were present.</p> <p>* On 5/14/18 at 5:20 PM, CNA #4 was called to assist Resident #33. CNA #4 asked Resident #33 where her cane was located, and stated she should be using it. CNA #4 stated she thought Resident #33 was cleared to walk without staff assistance by therapy as of 5/14/18.</p> <p>* On 5/14/18 at 6:39 PM, Resident #33 was observed walking into the dining room without staff assistance and without a cane.</p> <p>* On 5/16/18 11:49 AM, Resident #33 was in her wheelchair in the fenced court yard without supervision. She was seen leaning down to pick up a piece of paper from the ground while seated in her wheelchair. No staff were present for 20 minutes.</p> <p>* On 5/16/18 at 5:00-5:30 PM, Resident # 33 was in the lobby on the couch sitting with a cane at her side. No staff were present in the lobby area during this time. Her wheelchair was not present. Resident #33 did not have a wander guard on her person.</p> <p>* On 5/17/18 at 4:00 PM- 4:36 PM, Resident #33 was laying on the couch without a cane or wander guard. The MDS Nurse was asked to see Resident #33 in the lobby. On 5/17/18 at 4:36 PM, the MDS Nurse acknowledged there were</p>	F 689			

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F 689	Continued From page 38 no staff and no assistive devices or wander guard present. He stated Resident #33 had not been cleared by the Physical Therapy Department.  A 4/6/18 Physical Therapy Note documented Resident #33 was evaluated and treatment was ordered. The note documented Resident #33 required gait training, therapeutic activities, therapeutic exercise, neuro re-education, and manual interventions to address abnormal gait and mobility, 3 days per week.  A 5/14/18 Physical Therapy Note documented Resident #33 was a fall risk with limited cognition. The note documented that Resident #33 had need of a single point cane with mobility, that she had intermittent confusion that improved as they worked together.  On 5/18/18 at 1:08 PM, the Physical Therapist stated Resident #33 was still on services and required stand by assistance with transfers, bed mobility, and ambulation. The PT stated she should not be walking by herself and she required supervision and a cane.  On 5/18/18 at 11:50 AM, the DON and LPN #1 stated they thought she was released from physical therapy. The DON said he was unaware of Resident #33's care plan for a wander guard.	F 689			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)  §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to	F 690		6/15/18	

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F 690	<p>Continued From page 39</p> <p>maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.</p> <p>§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff and resident interview, review of the facility's bowel care protocol, and record review, it was determined the facility failed to consistently monitor bowel function for residents in accordance with standard nursing practice. This was true for 3 of 5 residents (#33, #68, and</p>	F 690	<p>SDC will provide education to all LN staff on the components of the bowel protocol by 06/15/2018. NP reviewed patient #82's medications list and appropriate modifications were made on 05/15/2018.</p>		

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F 690	<p>Continued From page 40</p> <p>#82) assessed for ordered bowel regimen. The facility failed to implement a bowel protocol order for Residents #33 and #68 and failed to hold a bowel medication for Resident #82. Residents #33 and #68 had the potential for harm from constipation or impaction. Resident #82 had the potential for harm from electrolyte imbalance related to increased fluid loss and/or infection from excess fecal contamination of open excoriated skin. Findings include:</p> <p>On 5/17/18 at 1:40 PM, the DON provided typed nursing orders for bowel protocol as follows:</p> <ul style="list-style-type: none"> <li>* Prune juice 4-8 ounce every 24 hours as needed for bowel care if no bowel movement (BM) for 48 hours.</li> <li>* Milk of magnesia (MOM) Give 30 cc by mouth every 24 hours as needed for bowel care if no BM for 3 days.</li> <li>* Dulcolax Suppository insert 10 mg rectally every 24 hours as needed for bowel care if no results from MOM.</li> <li>* Fleet enema insert 1 unit rectally every 24 hours as needed for bowel care if no results from Dulcolax.</li> </ul> <p>1. Resident #33 was admitted to facility on 2/14/17 with diagnoses which included traumatic brain hemorrhage, dementia, constipation, and cognitive communication deficit.</p> <p>A significant changed MDS assessment, dated 3/23/18, documented Resident #33 was severely cognitively impaired.</p> <p>The 4/1/18 through 4/30/18 Bowel Movement Record documented Resident #33 did not</p>	F 690	<p>DON or designee will audit bowel sheets three times per week for 12 weeks monitoring for constipation. The DON and ED will update the QA committee monthly for 3 months on findings. Further recommendations from the QA committee will be implemented.</p>		

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F 690	<p>Continued From page 41</p> <p>experience a bowel movement between 4/25/18 to 4/29/18 (4 days).</p> <p>The facility tracked all residents without a bowel movement in two days on a document called the Bowel Care List. The following was documented regarding Resident #33:</p> <ul style="list-style-type: none"> <li>* 4/27/18 - Resident #33 went two days without a bowel movement. There was no documentation prune juice was administered.</li> <li>* 4/28/18 Resident #33 went three days without a bowel movement and prune juice was administered and MOM was refused.</li> <li>* 4/29/18 Resident #33 went four days without a bowel movement and refused medication and suppository.</li> </ul> <p>Resident #33's 4/1/18 through 4/30/18 MAR did not document bowel protocol measures of prune juice, MOM, or a suppository were implemented or refused between those days. Resident #33's progress notes did not contain documentation she refused the bowel medications.</p> <p>Resident #33's Bowel Movement Record, Bowel Care List, Progress Notes, and MAR contained inconsistent data and conflicting interventions.</p> <p>On 5/17/18 at 12:00 PM, the DON stated staff was expected to treat residents with standard nursing practice and follow the bowel protocol.</p> <p>2. Resident #82 was admitted to the facility on 10/10/17 with diagnoses which included morbid obesity, irritable bowel syndrome without diarrhea, and constipation</p>	F 690			

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F 690	<p>Continued From page 42</p> <p>The quarterly MDS assessment, dated 4/27/18, documented Resident #82 was cognitively intact and was always incontinent of bowel.</p> <p>On 5/14/18 at 3:58 PM, Resident #82 stated she was having too many loose water bowel movements. She said her bottom was "raw" and "really hurt."</p> <p>Resident #82's physician's order dated 2/7/18, documented Resident #82 was to receive one Senna Plus tab by mouth two times a day. The order also documented to hold the medication for loose stools.</p> <p>An active order for Miralax was not found in Resident #82's medical record. The DON provided an order dated 1/29/18. Resident #82's Order Summary Report documented that on 2/7/18, the order for Miralax was discontinued.</p> <p>Resident #82's 3/1/18 through 5/14/18 MAR documented Resident #82 received 59 doses of Miralax out of 75 opportunities.</p> <p>The 5/1/18 through 5/14/18 Bowel Movement Record documented she was consistently experiencing 1 bowel movement per day except for the following:</p> <p>*On 5/6/18 Resident #82 had three documented bowel incontinent episodes. *On 5/9/18 Resident #82 had two bowel incontinent episodes. *On 5/12/18 Resident #82 had two bowel incontinent episodes.</p> <p>A Nursing Progress Note, dated 5/10/18,</p>	F 690			

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F 690	<p>Continued From page 43</p> <p>documented Resident #82 had redness to her groin and buttocks. The note documented Resident #82 frequently received incontinence care.</p> <p>On 5/15/18 at 9:20 AM, RN #1 stated she was aware Resident #82 was getting Miralax and Senna Plus daily and was aware Resident #82 was having frequent loose stools. RN #1 stated that Resident #82's skin excoriation was improving with new order for nystatin powder and ordered creams.</p> <p>The facility continued a discontinued order for Miralax for approximately 90 days and nursing staff failed to follow orders to hold the Senna Plus tab when Resident #82 experienced loose stools.</p> <p>3. Resident #68 was admitted to the facility on 5/1/15 with multiple diagnoses, including dementia with behavioral disturbances and generalized muscle weakness.</p> <p>Resident #68's annual MDS assessment, dated 4/19/18, documented she was severely cognitively impaired, totally dependent on staff for ADL assistance, and received hospice care.</p> <p>Resident #68's care plan documented she was at risk for bowel and bladder incontinence related to dementia and staff were directed to monitor Resident #68 for constipation and treat per bowel protocol, check for incontinence with morning and afternoon cares, before meals and as needed, monitor and document the number of episodes of elimination, incontinence per shift.</p> <p>Resident #68's May 2018 physician's orders</p>	F 690			

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F 690	Continued From page 44 included:  * Colace capsule 100 mg - give 2 capsules by mouth two times a day for constipation, * Miralax Powder 17 grams - mix 1 capful with glass of water or juice once a day for constipation * Milk of Magnesia (MOM) 30 cc - if no bowel movement for three days * Dulcolax suppository 10 mg - insert 1 suppository rectally every 24 hours for constipation if no results from Milk of Magnesia, * Fleet enema 7-19 grams - insert 1 unit rectally every 24 hours as needed for constipation if Dulcolax suppository is ineffective.  Resident #68's Bowel Movement Records, dated 4/17/18 through 5/17/18, documented she did not have a bowel movement between:  * 4/17/18 and 4/21/18 (5 days) * 5/8/18 and 5/11/18 (4 days)  Resident #68's MAR, dated 4/17/18 through 5/17/18, did not document that she received MOM during the days she was constipated.  On 5/17/18 at 1:48 PM, the DON reviewed the MAR and said MOM was not given to Resident #68 during the days she was constipated.  The facility failed to follow the physician orders for bowel care during the periods when Resident #68 had no bowel movements for more than three days, which placed Resident #68 at risk for complication related to constipation.	F 690			
F 698 SS=D	Dialysis CFR(s): 483.25(l)	F 698		6/15/18	

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F 698	<p>Continued From page 45</p> <p>§483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policies and resident records, it was determined the facility failed to ensure the facility consistently monitored a central venous catheter (CVC) used for dialysis. This was true for 1 of 1 (#3) resident reviewed for dialysis. This deficient practice placed Resident #3 at risk of infection, bleeding, or displacement of central venous catheter when the facility failed to assess the catheter daily and update the resident's care plan to include the central venous catheter and related interventions. Findings include:</p> <p>Resident #3 was admitted to facility on 2/21/17, with diagnoses which included end stage renal disease and a dependence on dialysis.</p> <p>An annual MDS assessment, dated 5/3/18, documented Resident #3 was cognitively intact.</p> <p>The facility's policy and procedure for dialysis documented:</p> <ul style="list-style-type: none"> <li>* Assess resident daily for function related to dialysis.</li> <li>* Any problems with the resident's access should be addressed "IMMEDIATELY".</li> <li>* Excessive bleeding from graft site, redness, swelling, pain, or non-functioning graft requires medical attention and notification to the medical</li> </ul>	F 698	<p>No current CVC devices in house.</p> <p>MDS or designee will complete an audit monitoring for residents with a CVC weekly for 12 weeks.</p> <p>SDC or designee will educate licensed staff on required Q shift monitoring of the CVC by 06/15/2018.</p> <p>The DON and ED will update the QA committee monthly for 3 months on findings. Further recommendations from the QA committee will be implemented.</p>		

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F 698	<p>Continued From page 46 provider. * Documentation: Assess care given and condition of renal access.</p> <p>A Nursing Progress Note, dated 4/28/18, documented Resident #3 had a newly placed central venous catheter to the right chest for hemodialysis.</p> <p>Nursing Progress Note documented Resident #3's right chest CVC was assessed on 4/29/18, 4/30/18, 5/5/18, 5/6/18, and 5/10/18.</p> <p>On 5/14/18 a verbal order issued by a healthcare practitioner documented staff were to monitor Resident #3's dialysis catheter, to his right chest, one time a day until it was discontinued.</p> <p>The facility documented in Resident #3's care plan on 5/14/18, a new order to monitor CVC.</p> <p>The facility updated the treatment administration record (TAR) 5/14/18. The catheter was placed in right upper chest on 4/28/18.</p> <p>On 5/16/18 at 2:11 PM, the DON stated Resident #3's catheter was placed in April and the facility staff would monitor the site daily for a newly placed CVC and then periodically after that. The DON stated the staff did not assess the location daily as specified in the facility's policy, prior to 5/14/18. The DON stated there was no update to the care plan for the dialysis CVC prior to 5/14/18.</p> <p>The facility failed to ensure orders, monitoring, and a care plan were in place for a new dialysis CVC access site in a timely manner.</p>	F 698			

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F 700 SS=E	<p>Bedrails CFR(s): 483.25(n)(1)-(4)</p> <p>§483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</p> <p>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.</p> <p>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of I&amp;A reports, and resident and staff interview, it was determined the facility failed to ensure appropriate alternatives were identified and attempted, consents obtained, and safety assessments were completed prior to the installation of bed rails. This was true for 5 of 7 sample residents (#16, #31, #41, #49, and #54) reviewed for bed rail use. The failure created the potential for harm if residents were to become entrapped in bed rails, experience falls, or were otherwise injured due to the use of bed rails.</p>	F 700	<p>Therapy will evaluate residents before placement of side rail or side rails.</p> <p>Licensed staff educated on side rail placement, that if requested by the patient or needed that therapy will evaluate, and if appropriate that an order, consent for the device and care plan update are required for placement of the side rails to a patients bed.</p> <p>IDT will assess all residents with bed rails</p>	6/18/18	

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F 700	<p>Continued From page 48</p> <p>Findings include:</p> <p>1. Resident #41 was admitted to the facility on 12/18/17 with diagnoses which included cerebral palsy, abnormal posture, and contractures of bilateral upper extremities including shoulders, elbows, wrists, and hands.</p> <p>A quarterly MDS assessment, dated 3/29/18, documented Resident #41 was cognitively intact and required extensive assistance of 2 staff members with bed mobility. The MDS assessment documented bed rails were not used as a restraint. The assessment documented Resident #41 had range of motion and functional limitation impairment in both upper and lower extremities.</p> <p>Resident #41's care plan, dated 12/19/17, documented she required 2 staff member assistance with bed mobility to reposition. The care plan also documented Resident #41 had bilateral 1/4 bed rails to promote independence with bed mobility. The care plan contradicted itself.</p> <p>An Initial Nursing Assessment, dated 12/18/17, documented Resident #41 had contractures to her hands, fingers, hips, knees, and foot. The assessment documented she had weakness to her right and left arms and legs. The assessment documented she had range of motion impairments to her neck, shoulders, elbows, wrists, fingers, hips, knees, ankles, toes, and other joints. The assessment documented she had "Full Loss" of voluntary movement to the same areas.</p>	F 700	<p>for safety and need by 06/15/2018.</p> <p>If the bed rail is determined appropriate for the resident, a physicians order, consent, and safety assessment will be completed.</p> <p>DON or designee will audit twice per week for 12 weeks. The DON and ED will update the QA monthly for 3 months on findings. Further recommendations from the QA committee will be implemented.</p>		

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F 700	<p>Continued From page 49</p> <p>An I&amp;A Report, dated 12/23/17, documented Resident #41 was found on the floor on her right side.</p> <p>Resident #41's bilateral 1/4 bed rails were observed in the raised position on 5/14/18 at 10:10 AM, 5:33 PM, and 5:49 PM; and on 5/15/18 at 11:00 AM.</p> <p>On 5/14/18 at 5:33 PM, Resident #41 was receiving pericare from CNA #3 and CNA #2. CNA #3 and CNA #2 were observed turning and repositioning Resident #41 throughout the observation. Resident #41 did not utilize the bed rails to assist the CNAs with positioning during the observation. Resident #41 was observed while CNA #2 and CNA #3 utilized a mechanical lift to place her into her wheelchair.</p> <p>On 5/14/18 at 5:49 PM, Resident #41 was observed with contractures to her extremities.</p> <p>Resident #41's Restraint Enabling Device Safety Evaluation, dated 4/20/18, was completed after the bilateral bed rails were in place. The evaluation did not include Resident #41's diagnoses of cerebral palsy and did not include an evaluation of the risk for entrapment. The evaluation documented Resident #41 was able to utilize the bed rails to promote independence with bed mobility and the bed rails were not considered a restraint.</p> <p>Resident #41's bed rail consent form, dated 5/14/18, was completed after the bilateral bed rails were in place.</p> <p>On 5/17/18 at 6:18 PM, LPN #3 stated the</p>	F 700			

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F 700	<p>Continued From page 50</p> <p>resident wanted the bed rails due to a fear of falling. LPN #3 stated the manufacturer of Resident #41's bed frame required bed rails for safety purposes, due to the air mattress.</p> <p>2. Resident #16 was admitted to the facility on 2/13/18 with multiple diagnoses which included general muscle weakness and abnormal mobility.</p> <p>An admission MDS assessment, dated 2/20/18, documented Resident #16's cognition was severely impaired, extensive assistance with bed mobility and transfers was required, and bed rails were not used as a restraint.</p> <p>Resident #16's comprehensive care plan for ADL self care deficit included an intervention for bilateral 1/4 bed rails to promote independence with bed mobility. The intervention was initiated 3/18/18.</p> <p>The resident's active physician orders documented the bed rails were ordered on 3/18/18.</p> <p>Resident #16 was observed in bed with the bilateral bed rails in the raised position on 5/14/18 at 10:45 AM and 3:50 PM; on 5/15/18 at 10:12 AM, 11:30 AM, 12:44 PM, and 2:41 PM; on 5/16/18 at 12:15 PM and 2:15 PM, and 5/17/18 at 10:03 AM.</p> <p>A Restraint/Enabling Device/Safety Device Evaluation, dated 3/18/18, documented Resident #16 was a "New Admit." The evaluation documented the bed rails were not a restraint and that the resident was able to utilize the bed rails "safely" to promote independence with bed</p>	F 700			

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F 700	<p>Continued From page 51 mobility. The evaluation did not include an assessment of the resident for risk of entrapment.</p> <p>On 5/17/18 at 6:18 PM, LPN #3 said Resident #16 wanted the bed rails.</p> <p>3. Resident #31 was admitted to the facility on 3/15/18 with multiple diagnoses which included right side hemiplegia (one side paralysis) and general muscle weakness.</p> <p>Resident #31's admission MDS assessment, dated 3/22/18, documented intact cognition, extensive assistance by 2 people was needed for bed mobility and transfers, functional limitation in ROM in 1 upper extremity and 1 lower extremity, and bed rails were not used as a restraint.</p> <p>Resident #31's baseline care plan and comprehensive care plan for falls, both dated 3/15/18, documented one intervention was, "Side rails as ordered." The comprehensive care plan for ADL self care deficit, dated 3/15/18, documented bilateral 1/4 bed rails were initiated on 4/16/18.</p> <p>Resident #31's left bed rail was observed in the raised position on 5/14/18 at 4:15 PM; on 5/15/18 at 10:00 AM, 11:00 AM, 12:22 PM and 2:22 PM; and on 5/16/17 at 11:13 AM.</p> <p>On 5/18/18 at 10:26 AM, bilateral bed rails were observed in the raised position and Resident #31 said she used the bed rails to help her move in bed and to get in and out of bed.</p> <p>A bed rail consent, dated 3/15/18, documented</p>	F 700			

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F 700	<p>Continued From page 52</p> <p>Resident #31 consented to the use of one upper bed rail on the right side. Another bed rail consent, dated 4/28/18, documented the resident consented to the use of bilateral upper bed rails.</p> <p>A Restraint/Enabling Device/Safety Device Evaluation, dated 4/16/18, documented Resident #31 was a "New Admit." The evaluation documented, "Resident desires use of side rail...and...is able to use device safely."</p> <p>No other Restraint/Enabling Device/Safety Device Evaluations were found in Resident #31's clinical record and the facility did not provide any other bed rail evaluations.</p> <p>An assessment of Resident #31's risk of entrapment was not completed prior to the implementation of any bed rail. In addition, the consent for the bilateral bed rails was obtained 12 days after the bed rails were placed on the resident's bed.</p> <p>On 5/17/18 at 6:18 PM, LPN #3 said the 4/28/18 consent was late and the resident wanted the bed rails.</p> <p>4. Resident #49 was admitted to the facility on 12/24/17 and readmitted on 2/9/18 with multiple diagnoses which included left hip traumatic arthropathy (condition or disease of a joint), muscle weakness, abnormal gait, chronic pain syndrome, and Alzheimer's disease.</p> <p>Resident #49's admission MDS assessments, dated 12/30/17 and 2/16/18, both documented moderately impaired cognition, usually understood by others and usually able to</p>	F 700			

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F 700	<p>Continued From page 53</p> <p>understand others, extensive assistance with bed mobility and transfers required, and bed rails were not used as a restraint.</p> <p>Resident #49's ADL self care deficit care plan, initiated 12/24/17 and revised 2/22/18, documented bilateral bed rails were initiated on 3/18/18.</p> <p>The resident's active physician orders documented bilateral bed rails were ordered on 3/18/18 to promote independence with bed mobility.</p> <p>Bilateral bed rails were observed in the raised position on Resident #49's bed on 5/14/18 at 10:30 AM, 11:20 AM and 4:18 PM; on 5/15/18 at 10:03 AM, 11:00 AM, and 12:30 PM; and on 5/16/18 at 2:31 PM.</p> <p>A Restraint/Enabling Device/Safety Device Evaluation, dated 3/18/18, documented Resident #49 was a "New Admit." There was no documented evidence in Resident #31's clinical record that an assessment of the resident for risk of entrapment was completed prior to the implementation of the bed rails.</p> <p>Resident #31 signed a consent for bilateral bed rails on 5/1/18, 49 days after the bed rails were implemented.</p> <p>On 5/17/18 at 6:18 PM, LPN #3 said the bed rails were initiated because the resident wanted them and that consent for the bed rails was obtained after the bed rails were implemented.</p> <p>5. Resident #54 was admitted to the facility on</p>	F 700			

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F 700	Continued From page 54 12/29/17 with multiple diagnoses, including stress fracture of the right humerus (bone of the upper arm) and generalized muscle weakness.  On 5/14/18 at 3:30 PM and 4:24 PM, Resident #54 was observed in bed sleeping, with her bed against the wall, and the left bed rail was observed in the raised position.  Resident #54 care plan did not document the use of a bed rail.  There was no documentation found in Resident #54's clinical record that the bed rail was assessed for safety, consent signed for bed rails, or an order was obtained for use of bed rails.  On 5/15/18 at 10:44 AM, RN #3 said Resident #54 should not have a bed rail and she did not know why her bed rail was in place. RN #3 also said residents who have bed rails should have a physician's order, be assessed for safety, and have the bed rails included on their care plans.  On 5/15/18 at 11:10 AM, Resident #54 said her bed rail was always in the raised position.	F 700			
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)  §483.45(f) Medication Errors. The facility must ensure that its-  §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to	F 759	SDC or designee will educate all licensed nurses on the eight rights of medication	6/15/18	

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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 759	Continued From page 55 ensure the medication error rate was less than 5%. This was true for 2 of 26 medications (7.69%) which affected 2 of 5 residents (#45 and #67) whose medication administration was observed. The failure created the potential for sub-therapeutic effect when Resident #45's powder laxative was mixed in less fluid than recommended and when Resident #67 was administered the wrong dose of an inhaled corticosteroid medication. Findings include:  1. On 5/17/18 at 8:00 AM, LPN #3 was observed as she poured 14 medications for Resident #45, including 17 grams (one capful) of polyethylene glycol powder. The dry powder was in a small plastic cup and the LPN poured 3 ounces of water in another small plastic cup. LPN #3 said she would mix the powder in the water in the resident's room if the resident agreed to take it. When LPN #3 said she was ready to take the medications to Resident #45, she was asked how much water was in the cup to mix with the polyethylene glycol powder. LPN #3 measured 3 ounces of water in the cup. LPN #3 then read the label on the bottle of polyethylene glycol which instructed 4 to 8 ounces of fluid and said that 3 ounces was not enough water. Immediately after that, LPN #3 obtained a larger glass with approximately 6 ounces of water, which she took to the resident's room with the medications. When the resident agreed to take the polyethylene glycol, the LPN mixed the powder in the 6 ounces of water and administered it to the resident.  2. On 5/17/18 at 5:45 PM, LPN #2, was observed as she poured 2 medications for Resident #67, including Flonase nasal spray. The pharmacy	F 759	administration by 06/15/2018.  SDC or designee will observe random LN staff for medication administration twice per week for 12 weeks. The DON and ED will update the QA committee monthly for 3 months on findings. Further recommendations from the QA committee will be implemented.		

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F 759	Continued From page 56 label on the Flonase instructed 2 sprays in each nostril daily as needed. The LPN administered 1 spray in each of the resident's nostrils. At 5:50 PM, LPN #2 was asked to reread the pharmacy label on the resident's Flonase, which she did. LPN #2 then read the physician's order and the MAR instructions for the Flonase, both of which documented 2 sprays daily as needed. LPN #2 said she misread the label instructions on the resident's Flonase. LPN #2 then returned to Resident #67's room and administered another spray of Flonase in each of the resident's nostrils.	F 759			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)  §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  §483.45(h) Storage of Drugs and Biologicals  §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution	F 761		6/15/18	

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F 761	<p>Continued From page 57</p> <p>systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, and record review, it was determined the facility failed to ensure pharmacy labels matched physician orders and the MAR for 1 of 23 prescription medications. This was true for 1 of 5 residents (#45) during medication pass observations. The failure created the potential for Resident #45's anticonvulsant medication, lamotrigine (anticonvulsant), to be administered at the wrong time. Findings include:</p> <p>On 5/17/18 at 8:00 AM, LPN #3 was observed as she poured 14 medications for Resident #45, including the lamotrigine. The lamotrigine pharmacy label documented the medication was to be administered at bedtime. When LPN #3 said she was ready to administer the medications, she was asked to reread the lamotrigine pharmacy label, which she did. LPN #3 said the resident's lamotrigine was "always" administered in the morning and that the pharmacy label was wrong. The LPN said she would contact the pharmacy about the error.</p> <p>Resident #45's active physician orders for May 2018, documented the lamotrigine was ordered one time since 3/2/18 and the May 2018 MAR documented it was scheduled for 7:00 AM daily.</p> <p>On 5/17/18 at 10:00 AM, LPN #1, said the pharmacy had been contacted about the label error for Resident #45's lamotrigine.</p>	F 761	<p>Direction change sticker added to the non-matching card for resident #45 on 05/18/2018, pharmacy notified of the discrepancy, the order was updated in there system and a new card of medications with the correct label was delivered to the facility.</p> <p>DON or designee will complete weekly audit of four residents medications verifying that the physician order to pharmacy instructions are correct on medication cards for 12 weeks.</p> <p>Licensed staff educated that if discrepancies are noticed on medication cards to notify pharmacy as to update orders in their system and to send a new card. A change of order sticker will be added to the incorrect card to alert licensed staff.</p> <p>Any discrepancies will be resolved, pharmacy will be notified. The DON and ED will update the QA committee monthly for 3 months on findings. Further recommendations from the QA committee will be implemented.</p>		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		6/18/18	

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F 812	Continued From page 58  §483.60(i) Food safety requirements. The facility must -  §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.  §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure measures were in place to prevent possible cross-contamination of dirty to clean areas in the kitchen. This affected 16 of 16 (#3, #16, #18, #29, #31, #33, #41, #45, #49, #54, #56, #67, #68, #77, #82, and #135) sample residents who resided in the facility and the 65 other residents who dined in the facility. This failure created the potential for harm if residents contracted foodborne illnesses. Findings include:  On 5/17/18 at 2:27 PM, a Dishwasher and Dietary Aide (DA) #1 were observed during the dish washing process. DA #1 was observed	F 812	Will provide staff education on preventing cross-contamination by 06/15/2018.  Dietary manager or designee will ensure compliance with cross-contamination prevention by ensuring staff are wearing aprons, monitoring for plate ware coming in contact with person, and contact with potential food contaminants or soiled surfaces, equipment, and utensils twice per week for 12 weeks.		

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F 812	Continued From page 59 during the dishwashing process placing cleaned dried dishes into their storage areas. DA #1 was not wearing an apron. DA #1 removed the cleaned dishes from the trays and rested the clean dishes against her chest to carry them towards their storage area.  The Certified Dietary Manager (CDM), present during the observation, stated this was not the correct procedure for handling clean dishware. She stated DA #1 should not allow dishes to touch her body while carrying dishes. The CDM stated the dishes should be carried away from the body or placed on a cart to transport them to the appropriate area. The CDM had the Dishwasher re-sanitize the dishes.	F 812			
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4)  §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.  §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet	F 849		6/15/18	

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F 849	Continued From page 60 professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice	F 849			

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F 849	<p>Continued From page 61</p> <p>representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.</p> <p>(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.</p> <p>(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.</p> <p>(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.</p> <p>(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.</p> <p>§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the</p>	F 849			

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F 849	Continued From page 62 facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's	F 849			

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F 849	<p>Continued From page 63 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.</p> <p>§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review, review of a contract between a hospice provider and the facility, and staff interview, it was determined the facility failed to ensure care was coordinated with a hospice provider and duties of the hospice provider and the facility were delineated. This was true for 1 of 2 residents (#68) sampled for hospice care. The lack of communication and coordination created the potential for Resident #68 to receive inadequate care. Findings include:</p> <p>Resident #68 was admitted to the facility on 5/1/15 with multiple diagnoses, including dementia with behavioral disturbances and generalized muscle weakness.</p> <p>Resident #68's annual MDS assessment, dated</p>	F 849	<p>Social services or designee will conduct an audit of all hospice patients reviewing that a plan of care is in place for residents who are on hospice, this will be completed by 06/15/2018.</p> <p>Social services will be educated on what details need to be in the residents care plan.</p> <p>DON and Unit manager will be the liaison for coordination of care between hospice entities. The plan of care will be reviewed with the hospice nurse or liaison upon admission, with change of condition, and during care conferences quarterly.</p>		

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F 849	<p>Continued From page 64</p> <p>4/19/18, documented she was severely cognitively impaired, totally dependent on staff for ADLs assistance, and received hospice care.</p> <p>Resident #68's care plan documented she had a terminal prognosis related to Alzheimer's (problems with memory, thinking and behavior) disease and had elected to be DNR. Interventions included hospice to provide nursing, social services, clergy and ADL support, provide additional bathing and supply incontinent products, and directed staff were to call the hospice provider with questions or significant changes, keep the environment quiet, calm, dry, and wrinkle free, and keep lighting low and familiar objects near.</p> <p>On 5/16/18 at 4:10 PM, CNA #4 said the hospice representative came to the facility and provided nursing care to Resident #68 according to their schedule and checked in with the nurse. CNA #4 also stated the facility provided nursing care to Resident #68 24 hours a day.</p> <p>On 5/17/18 at 1:48 PM, the DON said the facility provided 24 hour services to Resident #68 and called the hospice provider when they had a concern with the resident. The DON provided a copy of the hospice care plan and facility contract with the hospice provider the following day.</p> <p>Included in the contract was Exhibit D "Designation of Hospice &amp; [and] Facility Roles and Responsibilities." The DON was unable to provide designation of duties between the facility and the hospice provider specific for Resident #68. This lack of communication or coordination of care between the facility and hospice provider</p>	F 849	<p>Hospice liaison will meet with the hospice entity and agree to the services they provide and sign the plan of care acknowledging the coordination of care and the delineation of the duties between the two entities.</p> <p>All hospice patients will be reviewed on a weekly basis, ensuring that a plan of care is in place and up to date for 12 weeks. The DON and ED will update the QA committee monthly for 3 months on findings. Further recommendations from the QA committee will be implemented.</p>		

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F 849	Continued From page 65 placed Resident #68 at risk of lack of care by both providers.	F 849			
F 880 SS=E	<p>Infection Prevention &amp; Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§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 development and transmission of communicable diseases and infections.</p> <p>§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:</p> <p>§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;</p> <p>§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</p>	F 880		6/15/18	

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F 880	<p>Continued From page 66 reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§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 observation and staff interview, it was determined the facility failed to ensure hand hygiene was performed and completed correctly, tube feeding product was refrigerated after</p>	F 880	<p>Education will be provided to all LN staff on the proper storage of tube feeding supplements. Education will be provided to all care staff</p>		

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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>		
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F 880	<p>Continued From page 67</p> <p>opened and unused, and catheter bags did not touch the floor. This was true for 4 of 18 residents (#18, #41, #56, and #135) reviewed for infection control. These failures created the potential for the spread of infection among residents. Findings include:</p> <p>The Centers for Disease Control and Prevention (CDC) recommend the following procedure for hand hygiene with soap and water:</p> <ul style="list-style-type: none"> <li>* Wet hands first with water,</li> <li>* Apply the recommended amount of anti-bacterial soap,</li> <li>* Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers,</li> <li>* Rinse hands with water and use disposable towels to dry, and</li> <li>* Use towel to turn off the faucet.</li> </ul> <p>The CDC guidelines also documented other entities had recommended cleaning hands with soap and water for approximately 20 seconds and documented either amount of time was acceptable.</p> <p>Best Practice for Managing Tube Feeding A Nurse's Pocket Manual, dated 2015, documented "Preventing Contamination of Formula and Delivery System Used for Adults ... 3. Maintain proper storage and handling of formula: A. Thoroughly clean the top of formula containers before opening B. Record date/time formula is opened C. Cover opened, unused formula in refrigerator ..."</p> <p>The above standards of practice were not</p>	F 880	<p>on proper hand hygiene techniques and return demonstration.</p> <p>Education will be provided to all care staff on catheter bag positioning</p> <p>Education will be provided to all care staff on infection control when assisting residents with meals.</p> <p>All education pieces will be completed by the 15th of June 2018.</p> <p>Audits will be performed two times per week for 12 weeks beginning the 18th of June 2018</p> <p>SDC or designee will audit the dining rooms randomly 2x a week for 12 weeks, monitoring for infection control measures.</p> <p>SDC or designee will audit 2 times a week at random times for 12 weeks for proper placement of catheter bags.</p> <p>SDC or designee will audit 2 times a week for 12 weeks that tube feeding supplements are being refrigerated. The DON and ED will update the QA committee monthly for 3 months on findings. Further recommendations from the QA committee will be implemented.</p>		

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F 880	<p>Continued From page 68 followed. Examples include:</p> <p>1. On 5/14/18 from 11:52 AM and 12:21 PM, CNA #1 was observed during the lunch meal service in the Big Band Dining Room feeding Resident #56 and Resident #135 their beverages and their lunch meals. CNA #1 was observed through the observation with her chin rested on the palm of her left hand and her fingernails curled into her mouth, scratching her face, brushing her hair out of her face, and wiping her own mouth off while continuing to feed Resident #56 and Resident #135. CNA #1 was observed using her left hand to adjust the edge of Resident #56's straw after she had wiped the corner of her mouth with her left hand. Throughout the observation CNA #1 did not perform hand hygiene practices.</p> <p>On 5/14/18 at 12:54 PM, CNA #1 stated she did not realize she had touched her face.</p> <p>2. On 5/14/18 from 10:11 AM to 5:19 PM an opened and used container of Jevity 1.2 (tube feeding formula) was observed placed on a bedside table with a control method to cool it down. This was also observed on 5/15/18 at 11:00 AM.</p> <p>On 5/15/18 at 11:13 AM, the DON was shown the standards of practice for tube feeding safety and stated, the tube feeding formula should be refrigerated if not used.</p> <p>3. On 5/14/18 at 5:33 PM, Resident #41 was receiving pericare from CNA #3 and CNA #2. CNA #3 removed the soiled attends and proceeded to wipe the resident with wet wipes. CNA #3 took her gloves off and asked CNA #2 to</p>	F 880			

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F 880	<p>Continued From page 69</p> <p>finish while she washed her hands. CNA #3 disposed of the soiled attends and gloves and approached the sink to wash her hands. CNA #3 turned the water on, applied soap, rinsed her hands, and turned the water off within 7 seconds. While CNA #3 was washing her hands, CNA #2 continued to clean Resident #41. CNA #2 and CNA #3 applied Resident #41's clean attends and handled the sling for a mechanical lift with her used gloves. CNA #2 did not change her gloves or wash her hands after transition between dirty to clean. CNA #2 assisted Resident #41 into her wheelchair with the used gloves and touched Resident #41's blanket that went between her contracted legs. Once Resident #41 was situated in the chair CNA #2 removed her gloves and washed her hands, turned the water on, applied soap, rinsed her hands, and turned the water off within 5 seconds.</p> <p>4. On 5/14/18 at 5:56 PM, Resident #18's catheter drainage bag was observed on the floor in a dining room.</p> <p>On 5/14/18 at 6:01 PM, RN #5 stated the catheter bag was not attached properly to Resident #18's wheelchair. RN #5 stated the catheter bag should not have touched the floor.</p> <p>On 5/17/18 at 11:07 AM, RN #3 who identified herself as the Infection Control Nurse said the facility performed hand washing surveillance every 3 months randomly. RN #3 stated staff should wash their hands before and after resident contacts and when their hands were visibly soiled staff should wash their hands. RN #3 stated the facility staff could utilize hand sanitizer or soap and water throughout the</p>	F 880			

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F 880	Continued From page 70 facility.	F 880			
F 883 SS=D	<p>Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)</p> <p>§483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the</p>	F 883		6/22/18	

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F 883	<p>Continued From page 71</p> <p>immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, the facility failed to ensure pneumococcal immunizations were administered consistent the current CDC recommendations and that pneumococcal immunization consent forms reflected the current CDC recommendations . This was true for 1 of 5 sampled residents (#33) reviewed for pneumococcal immunizations. Findings include:</p> <p>The CDC website, updated on 11/30/15, recommended pneumococcal vaccination (PCV13 or Prevnar13®, and PPSV23 or Pneumovax23®) for all adults 65 years or older as follows:</p> <p>*Give a dose of PCV 13 to adults 65 years or older who have not previously received a dose.</p>	F 883	<p>Patient will be vaccinated with Prevnar 13 by 6/22/18.</p> <p>Building audit completed of all residents, immunization history updated for these residents.</p> <p>SDC or designee will educate LN staff on recommended CDC guidelines for pneumococcal immunizations that are consistent with the current CDC guidelines by 06/15/2018.</p> <p>Consent forms have been reviewed and were updated to reflect current CDC guidelines updated 10/31/2017.</p> <p>Consent forms will be updated as new</p>		

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F 883	<p>Continued From page 72</p> <p>Then administer a dose of PPSV23 at least 1 year later.</p> <p>*If the patient already received one or more doses of PPSV23, give the dose of PCV13 at least 1 year after they received the most recent dose of PPSV23.</p> <p>The CDC recommendation above was earlier issued 11/30/15.</p> <p>Resident #33 was readmitted to the facility on 4/14/18 with multiple diagnoses including traumatic subdural hemorrhage (brain injury) without loss of consciousness. Her age was greater than 65 years.</p> <p>Resident #33's immunization Electronic Medical Record (EMR) documented she required Prevnar13.</p> <p>On 5/17/18 at 11:00 AM, RN #3 said Resident #33 did not received Prevnar 13 according to the entry on her EMR. RN#3 said she would ask for Resident #33's paper chart from the medical records and look for more information regarding her vaccination.</p> <p>On 5/21/18 at 4:47 PM, the facility faxed Resident #33's consent for immunization dated 2/14/17 and February 2017's MAR to Bureau of Facility Standards (BFS). Resident #33's February 2017's MAR, documented she received Pneumococcal 23 vaccine on 2/20/17. No documentation was provided to describe the reason Resident #33 received the Pneumococcal 23 vaccine prior to the PCV 13 vaccine Documentation that Resident #33 received the</p>	F 883	<p>recommendations are announced. The DON and ED will update the QA committee monthly for 3 months on the findings. Further recommendations from the QA committee will be implemented.</p>		

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F 883	<p>Continued From page 73</p> <p>PCV 13 vaccine a year after receiving the Pneumococcal 23 vaccine was not provided by the facility.</p> <p>Resident #33's consent form, dated 2/14/17, documented her Power of Attorney (POA) gave verbal consent for her to receive "Pnu23."</p> <p>The facility's Pneumococcal Informed Consent form included the following information:</p> <p>*Clinical symptoms of pneumonia, *Population that should receive Pneumococcal Vaccine which include "all adults 65 years of age and older, resident in care centers...Second dose is recommended for residents 65 years or older, that received first dose prior to age 65. If second dose is given, it should be given 5 years after initial dose." *Clinical side effects of Pneumococcal Vaccine, and *Vaccine information statement provided to resident which included the resident had been educated on the benefits and risks associated with the Pneumococcal Polysaccharide Vaccine (PPSV).</p> <p>The facility's Pneumococcal Immunization Informed Consent form did not include information regarding the Prevnar13 vaccine or what type of Pneumococcal vaccine will be given after the first dose was administered.</p>	F 883			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001480</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/18/2018</b>
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C 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification, State licensure, and complaint survey conducted May 14, 2018 to May 18, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Linda Kelly, RN, Team Coordinator Presie Billington, RN Teresa Kobza, RD/LD Teri Hobson, RN</p>	C 000		
C 664	<p><b>02.150,02,a Required Members of Committee</b></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 record review and staff interview, it was determined the facility failed to ensure committee members participated in Infection Control Meetings. This failure has the potential to affect all residents, staff and visitors to the facility. Findings include:</p> <p>On 5/14/18 at 5:41 PM, RN #3 said she was also the facility's infection control nurse and that the facility conducted monthly Infection Control meetings.</p> <p>Infection Control Committee attendance records, dated, 6/27/17, 8/30/17, 9/27/17, 10/25/17, 11/29/17, 1/31/18, and 3/28/18, documented:</p> <p>* A representative from housekeeping did not</p>	C 664	<p>Infection control committee members will be educated on the mandatory attendance of this meeting by 06/15/2018, and will be made aware of the requirement to attend or send a designee in place of there department when this meeting is held.</p> <p>Administrator or designee will audit attendee list monthly ensuring that attendees required for the meeting are in attendance. Audit will be performed per the infection control meeting schedule for 12 weeks. The DON and ED will update the QA committee monthly for 3 months on the findings. Further recommendations from the QA committee</p>	6/15/18

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
Electronically Signed

TITLE

(X6) DATE  
06/13/18

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001480</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/18/2018</b>
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C 664	<p>Continued From page 1</p> <p>participate in any of the meetings.                      * The Pharmacist did not participate in the June, August, September, or October meetings.                      * A representative from maintenance did not participate in the June, August, October, November, or January meetings.                      * The Dietary Manager did not participate in June, October, November, or January meetings.</p> <p>RN #3 did not offer any explanation as to why a representative from housekeeping did not participate in any of the meetings or why a representative from maintenance, as well as the Dietary Manager and Pharmacist did not consistently attend the meetings.</p>	C 664	will be implemented.	



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
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January 31, 2019

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

Provider #: 135076

Dear Mr. Gunderson:

On **May 18, 2018**, an unannounced on-site complaint survey was conducted at Meadow View Nursing And Rehabilitation. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007626**

A Federal complaint investigation was conducted in conjunction with the facility's Federal recertification state licensure survey on May 14, 2018 to May 18, 2018.

**Allegation #1:** The facility declined to send a resident to the hospital for an evaluation following a change in condition of a low blood sugar.

**Findings #1:** Eighteen residents were observed for quality of care, dietary services, resident rights, and rehabilitation services. Quality of care practices, such as staff interaction with residents, answering call lights, participating in physical therapy, and answering phones, were observed. The facility's grievance files were reviewed, as well as its social service concerns.

Nine residents, five certified nursing assistants, and ten nurses were interviewed regarding various quality of life and care issues. The Director of Nursing and the Administrator were interviewed regarding various issues.

The clinical record of one resident documented she requested to go to the hospital despite having normal blood glucose levels. The facility, upon the resident's request, sent her to the hospital. Several nurses, social service workers, and the Director of Nursing stated if a resident requested to go to the hospital the facility would send them.

Residents were sent to the hospital for evaluation. Therefore, the allegation was unsubstantiated due to lack of sufficient evidence.

**Conclusion #1:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** A resident was not provided assistance with meals for three days and did not eat for three day and weight loss occurred.

**Findings #2:** Ten residents were observed and interviewed during meal times. They stated they received their meals, and assistance with meals, when requested.

One resident's clinical record documented she received multiple meals, for three days, prior to her hospitalization. Her clinical record documented she consumed 0 to 75 percent of her meals. The resident's clinical record documented staff offered her dietary alternatives when she did not eat a meal, however, the resident would refuse.

Residents were provided meal assistance. Therefore, the allegation was unsubstantiated due to lack of sufficient evidence.

**Conclusion #2:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #3:** A resident's family was unable to contact a resident during her stay at the facility and the facility would not return phone calls.

**Findings #3:** Eight residents were observed and interviewed receiving phone calls. The residents stated they did not have issues receiving messages or phone calls from families and friends.

The Grievance files from June 2017 through May 2018 were reviewed and no complaints of phones concerns were found.

Based on the results of the investigation, the allegation was unable to be substantiated.

**Conclusion #3:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #4:** A resident stated call light times were extended which resulted in being left on a bed pan and she developed a pressure ulcers.

**Findings #4:** Based on record review and interviews with staff and residents, it was determined the facility answered called lights timely and the resident did not develop a pressure ulcer.

Two residents were observed with pressure ulcers and they were repositioned as scheduled and provided pressure ulcer care as ordered.

Twelve residents were observed as their calls lights were answered by staff timely. Residents did not complaints about call light times lasting longer than ten to fifteen minutes.

The Grievance files from June 2017 through May 2018 were reviewed and no complaints of long call light times or being left on a bed pan were found.

A resident's clinical record documented she did not have a pressure ulcer or complain about long call light times.

Based on the results of the investigation, the allegation was unable to be substantiated.

**Conclusion #4:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #5:** Residents call bells were not answered timely.

**Findings #5:** Based on record review and interviews with staff and residents, it was determined the facility answered called lights timely.

Twelve residents were observed as their calls lights were answered by staff timely. Residents did not complain about call light times lasting longer than ten to fifteen minutes.

The Grievance files from June 2017 through May 2018 were reviewed and no complaints of long call light times were found.

A resident's clinical record documented she did not have complaints about long call light times.

Based on the results of the investigation, the allegation was unable to be substantiated.

**Conclusion #5:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #6:** Residents were not provided initial care conferences after readmission from the hospital, and the family was not notified timely of the meetings.

**Findings #6:** Based on record review and interviews with staff and residents, it was determined the facility did not provide communication with a resident's family and their care plan meeting.

A resident's record documented she did not have a care plan meeting after returning from the hospital.

The social worker and social worker assistant were interviewed and stated care plan meetings should have occurred when residents were re-admitted from the hospital.

Based on the results of the investigation, the allegation was substantiated. A deficiency was cited at F657 as it relates to the failure of the facility to ensure a care plan meeting occurred with the resident and their representative.

**Conclusion #6:** Substantiated. Federal deficiencies related to the allegation are cited.

**Allegation #7:** A resident did not receive physical therapy for two weeks after a readmission.

**Findings #7:** Based on record review and interviews with staff and residents, it was determined the facility provided physical therapy.

Four residents did not complain about not receiving physical therapy.

The Grievance files from June 2017 through May 2018 were reviewed and no complaints of residents not receiving physical therapy were found.

A resident's clinical record documented the physical therapist attempted to provide services and the resident was not awake enough to participate in services. The clinical record documented the resident's cognitive status was poor and when her mental status cleared the therapist would start the services. The record documented her cognitive status did not change prior to the resident's discharge from the facility.

Based on the results of the investigation, the allegation was unable to be substantiated.

**Conclusion #7:** Unsubstantiated. Lack of sufficient evidence.

Chase Gunderson, Administrator  
January 31, 2019  
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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 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".

LAURA THOMPSON, RN, Supervisor  
Long Term Care Program

LT/pmt



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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DAVE JEPPESEN – Director

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May 17, 2019

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

Provider #: 135076

Dear Mr. Gunderson:

On May 14, 2018 through **May 18, 2018**, an unannounced recertification and complaint survey was conducted at Meadow View Nursing and Rehabilitation. The complaint allegations, findings and conclusions are as follows:

**Complaint#ID00007618**

**ALLEGATION #1:**

The facility did not send appropriate documentation with a resident when they were transferred out of the facility.

**FINDINGS #1 :**

During the investigation five residents' records were reviewed for transfer and discharge requirements. Staff were interviewed for the transfer and discharge requirements.

One resident was admitted to the facility in August 2017 with diagnoses which included colon cancer, breast cancer, and a colostomy.

Review of one resident's record documented she was transferred from the facility to the hospital on 8/22/17 with complaints of nausea and abdominal pain.

A Progress Note documented the resident complained of nausea and her ostomy (opening in the colon) had green brown liquid stool. The note documented a nurse practitioner assessed the resident and offered

to send her to the hospital. The note documented the resident agreed to the hospital transfer and was transferred. The progress note did not document if written documents were given to the ambulance personnel or a written, verbal, or faxed report was provided to the hospital staff. The record did not include documentation of transfer information sent to the hospital.

The Director of Nursing Services (DNS) stated the facility provided a packet of information to the receiving facility during emergent transfers. She stated the facility sent information which included a face sheet, medication list, vital signs, a nursing progress note, physician orders, and advanced directive with a resident when transferring them to the hospital. She stated they did not have documentation of what documents were sent to the hospital with this resident.

Based on the investigative findings, the allegation was substantiated and a deficiency was cited at F622 as it related to the failure of the facility to ensure residents' medical information was provided to the transferring facility.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

#### ALLEGATION #2:

A resident's change of condition was not identified timely and the resident was not provided the option to go to the hospital when they asked.

#### ALLEGATION #2:

Three of three resident records were reviewed for documentation related to a change in condition and notification. The records reviewed did not include concerns regarding evaluations and changes in a resident's condition.

One resident's record, admitted in August 2017, included a nurse progress note, dated 8/22/17, which documented the resident complained of nausea and the resident had audible bowel sounds in the stomach, and her ostomy (opening in the colon) had green brown liquid stool. The note documented the resident was not experiencing vomiting and she declined pain medicine, anti-emetic medicine, and food and fluids. The note documented a nurse practitioner assessed the resident and offered to send her to the hospital. The note documented the resident agreed to the hospital transfer and was transferred. The note documented the family was notified of the transfer.

The DNS stated if a resident requested to go to the hospital the facility sent them.

Several CNAs said if they noticed a change of condition in residents, they immediately contacted the nurse. Several nurses said when residents experienced a change of condition they evaluated them and acted accordingly, including contacting the physician and family and sending the resident to the emergency room, if necessary.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility did not implement appropriate bowel care to prevent constipation.

FINDINGS:

During the investigation five resident records were reviewed for bowel care. Staff were also interviewed regarding bowel care.

A resident was admitted to the facility in May 2015, with multiple diagnoses including dementia with behavioral disturbances and generalized muscle weakness.

The resident's record documented orders for multiple medications for bowel protocol in the event of constipation issues. The resident's record documented he/she experienced multiple days of not having a bowel movement and the facility did not implement their bowel protocol.

The DNS stated the facility should have provided bowel care medications for the resident, and the medications were not provided.

Based on the investigative findings the allegation was substantiated and a deficiency was cited at F690 as it related to the failure of the facility to ensure their bowel protocol was implemented for residents with constipation.

FINDINGS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

Residents were not offered adequate hydration.

FINDINGS #4:

During the investigation resident records were reviewed and 13 residents were observed.

Thirteen residents were observed for signs of dehydration and availability of fluids to drink throughout the survey. Residents were observed during two different mealtimes in the dining room and in their rooms. Residents were observed at different times and during different activities throughout the survey.

Two of Two residents' records documented appropriate monitoring and interventions regarding residents' hydration status. The dietician and nursing staff were appropriately involved with those residents who had hydration concerns. Staff were observed providing appropriate amounts of fluids with meals, assisting residents to drink as needed, and offering fluids to residents throughout the day. The residents observed did not exhibit signs of dehydration.

Based on the investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

Residents family members were not notified of changes of condition or hospital transfers.

ALLEGATION #5:

Three resident records were reviewed for admission, transfer, and/or discharge.

One resident, admitted in August 2017, included a nurse progress note, dated 8/22/17, the resident complained of nausea. The note documented the resident had audible bowel sounds in her stomach and her ostomy (opening in the colon) had green brown liquid stool. The note documented the resident was not experiencing vomiting and she declined pain medicine, anti-emetic medicine, and food and fluids. The note documented a nurse practitioner assessed the resident and offered to send her to the hospital. The note documented the resident agreed to the hospital transfer and was transferred. The note documented the family was notified of the transfer.

Several nurses said when residents experienced a change of condition they evaluated them and acted accordingly, including contacting the physician and family and sending the resident to the emergency room, if necessary.

Based on the investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

Residents medications were not administered appropriately.

FINDINGS #6:

Chase Gunderson, Administrator  
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During the investigation ten residents were observed being provided medications. Interviews were conducted with residents regarding medication administration. Staff members were interviewed and observed providing medications. Facility grievances and Resident Council minutes were reviewed.

All ten residents' medication orders and Medication Administration records were reviewed for medication errors, including a resident admitted to the facility in August 2017. The residents' records documented their medications were administered as ordered by the physician.

Several nurses and several residents were observed during medication pass and residents received the correct medications as ordered. The nurses were observed explaining the medications to the residents before administration and interacted with the residents respectfully.

Based on the investigative findings 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 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,



Laura Thompson, RN, Supervisor  
Long Term Care Program

LT/lj