IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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TAMARA PRISOCK—ADMINISTRATOR
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3232 Elder Street
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Boise, Idaho 83720-0009
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July 13, 2018

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

Provider #: 135139

Dear Mr. Rudd:

On **June 29, 2018**, a survey was conducted at Riverview Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. 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 **July 23, 2018**. Failure to submit an acceptable PoC by **July 23, 2018**, may result in the imposition of penalties by **August 15, 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 <u>in column (X5)</u>.

  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 **August 3, 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 **September 27, 2018**. A change in the seriousness of the deficiencies on **August 13, 2018**, may

result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 29, 2018** includes the following:

Denial of payment for new admissions effective **September 29, 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 **December 29, 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 **September 29, 2018** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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 **July 23, 2018**. If your request for informal dispute resolution is received after **July 23, 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/

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135139		C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW REHABILITATION	3550 WEST AMERICANA TERRACE BOISE, ID 83706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during an on-site complaint survey conducted at Riverview Rehabilitation on June 29, 2018. The surveyors conducting the survey were: Teresa Kobza, RDN, LD, Team Coordinator Susan Devereaux, RN Abbreviations: DNS = Director of Nursing LSW = Licensed Social Worker NOMNC = Notice of Medicare Non-Coverage RN = Registered Nurse	F 000		
F 571 SS=D	Limitations on Charges to Personal Funds CFR(s): 483.10(f)(11)(i)-(iii) §483.10(f)(11) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15 of this chapter, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.) (i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities must not	F 571		7/31/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/20/2018

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 571	Continued From page 1 charge a resident for the following categories of items and services: (A) Nursing services as required at §483.35. (B) Food and Nutrition services as required at §483.60. (C) An activities program as required at §483.24(c). (D) Room/bed maintenance services. (E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing assistance, and basic personal laundry. (F) Medically-related social services as required at §483.40(d). (G) Hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan. (ii) Items and services that may be charged to residents' funds. Paragraphs (f)(11)(ii)(A) through (L) of this section are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if they are not required to achieve the goals stated in the resident's care plan, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:	F 571		

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F 571	Continued From page 2 (A) Telephone, including a cellular phone. (B) Television/radio, personal computer or other electronic device for personal use. (C) Personal comfort items, including smoking materials, notions and novelties, and confections. (D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare. (E) Personal clothing. (F) Personal reading matter. (F) Gifts purchased on behalf of a resident. (H) Flowers and plants. (I) Cost to participate in social events and entertainment outside the scope of the activities program, provided under §483.24(c). (J) Non-covered special care services such as privately hired nurses or aides. (K) Private room, except when therapeutically required (for example, isolation for infection control). (L) Except as provided in (e)(11)(ii)(L)(1) and (2) of this section, specially prepared or alternative food requested instead of the food and meals generally prepared by the facility, as required by §483.60. (1) The facility may not charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident's physician, physician assistant, nurse practitioner, or clinical nurse specialist, as these are included per §483.60. (2) In accordance with §483.60(c) through (f), when preparing foods and meals, a facility must take into consideration residents' needs and preferences and the overall cultural and religious make-up of the facility's population. (iii) Requests for items and services. (A) The facility can only charge a resident for any	F 571		

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F 571	Continued From page 3 non-covered item or service if such item or service is specifically requested by the resident. (B) The facility must not require a resident to request any item or service as a condition of admission or continued stay. (C) The facility must inform, orally and in writing, the resident requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure residents were not charged for services required to meet the needs for residents. This was true for 1 of 4 resident (#4) reviewed who required therapy services. The deficient practice created the potential for financial harm when the facility required the resident and family to pay for covered services. Findings include: Resident #4 was admitted to the facility on 1/31/18, with diagnoses which included muscle weakness, difficulty walking, and cerebral infraction. Resident #4's Insurance Verification Form documented she had no co-pay from 1-100 days. Resident #4's Admission Packet documented she was had a $0 co-pay from 1-100 days. Resident #4's Billing Transaction History, dated 1/31/18 through 2/28/18, documented she owed $837.50 dollars. On 6/29/18 at 2:18 PM, the LSW stated the	F 571	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Riverview Rehabilitation does not admit that the deficiencies listed on the CMS 2567 exists, nor does the facility admit to any statements, finding, facts or conclusion that form the basis for the alleged deficiencies. F571 □ Limitations on Charges to Personal Funds 1. Resident #4 no longer resides in this facility. The billing error, as soon as it was brought to the attention of the facility, was corrected by the facility Business Office Manager reflecting a zero-balance due for this resident. 2. All Qualified Medicare Beneficiaries have the potential to be affected by this cited deficient practice. On or before July 31, 2018, residents admitted to this facility since 1/1/2018	

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F 571	Continued From page 4 facility discussed an estimated general length of stay with the resident at the beginning of the residents stay. The LSW stated the social worker, nursing, and therapy meet as a team and discussed residents' progression during their therapies. The LSW stated the facility would provide a NOMNC to the resident after the team meeting occurred. On 6/29/18 at 3:56 PM, the Community Liaison stated it was a clerical error that Resident #4 was billed when she had a $0 co-pay.	F 571	have been reviewed by the corporate Accounts Receivable Specialist for billing errors. No other billing discrepancies were identified. 3. On or before July 31, 2018, the facility Business Office Manager and the Facility Director of Admissions were educated by the corporate Accounts Receivable Specialist regarding reading the Common Working File, specifically for QMB status. Additionally, in accordance with direction dated April 3, 2018 from the Department of Health and Human Services Centers for Medicaid and Medicare Services, Medicare-Medicaid Coordination Office, strongly encourage(d) plans that may have replicated (changes introduced into the Remittance Advice for Qualified Medicare Beneficiaries effective October 2, 2017 and discontinued December 8, 2017 due to the confusion they created) to discontinue them and produce replacement Medicare RA□s (for) providers"; meaning this facility should receive new RA□s for any patient that was a Qualified Medicare Beneficiary between October 2, 2017 and July 2, 2018 when the correct Remittance Advice Remark Codes (RARC□s) are implemented to clearly designate that "the beneficiary is enrolled in the QMB program and may not be billed for Medicare cost sharing amounts". 4. Effective July 2, 2018 under the direction of CMS Change Request (CR)	

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F 571	Continued From page 5	F 571	9911, Medicare Remittance Advice (otherwise known as the Explanation of Benefits) will include new messages for QMB beneficiaries and reflect $0 cost-sharing liability for the period enrolled in the QMB. These Medicare RA□s, as they are received, will be reviewed by the facility Business Office Manager and by the corporate Accounts Receivable Specialist to confirm that all Medicare cost sharing is billed appropriately. Beginning in the month of August for 3 months the facility Business Office Manager will report to the facility□'s Quality Assessment and Assurance committee the results of these reviews. Any concerns will be addressed, under the direction of the QAA committee, by Root Cause Analysis and Performance Improvement Plans as appropriate.	
F 572 SS=F	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident	F 572		7/31/18

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F 572	Continued From page 6 understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility's Admission Agreement, and staff interview, it was determined the facility failed to ensure the Admission Packet fully informed 2 of 2 sampled residents residing in the facility (#1 and #2) and the other 18 other residents residing in the facility, prior to, or at the time of admission, of their transfer and discharge rights. This deficient practice created the potential for residents to be discharged or transferred against their wishes due to a lack of understanding of their discharge and transfer appeal rights. Findings include: The facility's undated Admission Agreement documented, "Failure to Pay The Resident understands and agrees that he or she may be discharged from the Facility if the Resident/Responsible Party fails to make, or arrange to be made, any required payment by its due date... The Resident/Legal Representative agrees that if the overdue charges are not paid to the facility by the discharged date, the Resident must vacate the Facility on the date specified in the discharged notice if in accordance with the regulations found at 42 CFR 483.15(c)." CFR 483.15(c)(1)(ii) [F622] states, "The facility	F 572	F572 □ Notice of Rights and Rules 1. Resident #1 and Resident #2 no longer reside at this facility. 2. Residents admitted to the facility have the potential to be affected by a deficient practice in this area. On or before July 31, 2018 all current residents have been provided a copy of their Transfer/Discharge rights. 3. On or before July 31, 2018 the admission agreement has been modified with Transfer/Discharge rights information from Section 10 - Transfer and Discharge Rights copied to and duplicated in Section 2 - Payment Policies. 4. On or before July 31, 2018 and ongoing the facility admission staff will provide copies of the admission agreement with the Transfer/Discharge Rights duplicated in two sections. Beginning in August 2018, the facility	

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F 572	Continued From page 7 may not transfer or discharge the resident while the appeal is pending ..." On 6/29/18 at 3:24 PM, the Community Liaison stated she reviews the admission packet with residents. The Community Liaison stated the admission packet was reviewed and updated recently. The Community Liaison stated when she reviewed the current admission packet with residents she did not review CFR 483.15(c). The Community Liaison stated the admission packet did not state anything about the appeal process and it did "seem" like residents would be discharged without notice of appeal rights. On 6/29/18 at 5:04 PM, the Executive Director stated residents could review CFR 483.15(c) to know about the appeals process because the admission process did include the reference.	F 572	admission director will provide monthly reports to the facility Quality Assessment and Assurance Committee for three months on the number of admission agreements completed for the prior month, and whether there were any changes to the admission agreement. Any negative findings will be addressed through the QAA with Root Cause Analysis and Performance Improvement Plans as appropriate.	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.	F 582		7/31/18

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F 582	Continued From page 8 §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure	F 582	F582 Medicaid/Medicare Coverage/Liability notice	

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F 582	Continued From page 9 residents were provided advance notice of the reason their Medicare Coverage A was being terminated during their stay in the SNF and how to appeal the termination process. This deficient practice was true for 2 of 4 residents (#3 & #4) reviewed for notice of Medicare non-coverage. This failure created the potential for residents to experience financial distress and psychological harm when residents were not informed of how to appeal the ending of their Medicare coverage. Findings include: 1. Resident #4 was admitted to the facility on 1/31/18, with diagnoses which included muscle weakness, difficulty walking, and cerebral infraction (stroke). Resident #4's NOMNC letter documented Resident #4's Medicare coverage would end on 2/24/18. The notice had sections that read "You have a right to appeal this decision" and "How to ask for an immediate appeal" - which had the last bullet point of "Call your QIO [Quality Improvement Organization] at: (insert name and number of QIO) to appeal, or if you have questions." On 6/29/18 at 3:32 PM, the Guest Services personnel #1 stated she was unaware the QIO contact information was not included on the NOMNC form. The Guest Services personnel #1 stated she delivered and presented the NOMNC to residents. On 6/29/18 at 4:55 PM, the Executive Director stated the QIO number should be on the form. 2. Resident #3's admission record, dated of	F 582	1. Resident #3 and Resident #4 no longer reside at this facility. 2. All discharging Medicare Fee for Service beneficiaries have the potential to be affected by a deficient practice in this area. Beginning on or before July 31, 2018 all Medicare Fee for Service beneficiaries discharging from the facility have been given an updated Notice of Medicare Non-Coverage (NOMNC) to include the current contact information of the QIO. 3. On or before July 31, 2018 the facility Social Worker and the facility Guest Services Director were provided education by the facility administrator regarding the required information on the NOMNC. 4. Beginning in August 2018 issued NOMNC□s will be reviewed weekly for 4 weeks; every two weeks for 4 weeks; then monthly by the Admission Director or Designee to ensure that the NOMNC is appropriately completed before delivery to the Medicare beneficiary. Results of these audits will be provided monthly to the facility□'s QAA committee. Any identified problems will be address by Root Cause Analysis and Performance Improvement Plan monthly until 100% compliance is achieved.	

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	135139		C 06/29/2018

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F 582	Continued From page 10 1/31/18 and a readmission date of 2/18/18, included diagnoses of orthopedic aftercare, difficulty in walking, muscle weakness, cognitive communication deficit, traumatic subdural hematoma (collection of blood outside the brain), bradycardia (slower than normal heart rate), Parkinson's disease, and major depressive disorder. Resident #3's medical record included a discharge packet with the date of discharge as 2/27/18. Resident #3's NOMNC letter stated "The effective date coverage of your current skilled therapy services will end: February 26, 2018." The notice had sections that read "You have a right to appeal this decision" and "How to ask for an immediate appeal" - which had the last bullet point of "Call your QIO [Quality Improvement Organization] at: (insert name and number of QIO) to appeal, or if you have questions." In an interview on 6/29/18 at 4:55 PM, the Executive Director stated the QIO number should be on the form.	F 582		
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	F 622		7/31/18

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F 622	Continued From page 11 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 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. §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	F 622		

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F 622	Continued From page 12 medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (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). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including 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: Based on staff interview and record review, it	F 622	F622 Transfer and Discharge	

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F 622	Continued From page 13 was determined the facility failed to ensure all the discharge information was provided to the receiving care agency for 1 of 2 residents (#4) reviewed for discharges. 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 provided upon discharge. Findings include: Resident #4 was admitted to the facility on 1/31/18, with diagnoses which included muscle weakness, difficulty walking, and cerebral infraction (stroke). Resident #4 was discharged on 2/25/18. Resident #4's discharge packet included physician orders, physician progress notes, and a Discharge and Transition Form. The packet did not include Resident #4's advance directive information and comprehensive care plan goals. The Discharge and Transition Form, dated 2/13/18, documented Resident #4 was discharged on 2/25/18. The form documented her most recent vital signs which were documented on 2/12/18. The form did not include a physician's visit scheduled following discharge from the facility and was not signed by the resident or resident representative as reviewed during discharge. The form was not signed by the discharge RN. On 6/29/18 at 3:56 PM, the DNS stated she could not find a signed copy of the discharge form. The DNS stated she would expect her staff to review the form with residents and sign the form as reviewed prior to discharge. The DNS stated a follow up physician appointment should	F 622	Requirements 1. Resident #4 no longer resides in this facility. 2. All discharging residents have the potential to be affected by a deficient practice in this area. Beginning on or before July 31, 2018 discharging patients and their continuum providers have been given discharge information in accordance with CFR 483.15(c)(1)(i)(ii)(2)(i)-(iii). 3. On or before July 31, 2018 education was provided to the Interdisciplinary Team by the corporate Director of Clinical Operations and facility Director of Nursing on discharge packets and required information under CFR 483.15(c)(1)(i)(ii)(2)(i)-(iii). 4. Beginning August 1, 2018 Discharge Packets will be reviewed by the Director of Nursing or designee weekly for 4 weeks; every two weeks for 4 weeks; then monthly to ensure that the packet is completed before discharge. Results of these audits will be provided monthly to the facility□s QAA committee until 100% compliance is achieved. Any identified problems will be addressed by Root Cause Analysis and Performance Improvement Plan as appropriate.	

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F 622	Continued From page 14 have been made and documented on the form, and the vitals on the discharge form should have been more recent than 2/12/18. The DNS stated Resident #4's advance directive information and comprehensive care plan goals were not included in the discharge information sent with Resident #4.	F 622		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.	F 661		7/31/18

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F 661	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure appropriate information was documented in the resident's record and provided to the receiving health care provider upon discharge. This was true for 2 of 2 residents (#3 and #4) reviewed for discharge from the facility. This failure created the potential for harm and inappropriate care due to incomplete documentation related to the resident's discharge. Findings include: 1. Resident #4 was admitted to the facility on 1/31/18, with diagnoses which included muscle weakness, difficulty walking, encounter for other specific aftercare, and cerebral infraction. Resident #4 was discharged from the facility on 2/25/18. A Nurse's Note, dated 2/1/18, documented Resident #4 was admitted to the facility following generalized weakness due to a cardiopulmonary resuscitation (CPR) event following aspiration pneumonia and a left-sided stoke. When asked to provide a discharge summary for Resident #4, the facility provided a packet that included the following documentation, physician orders, physician progress notes, and a Discharge and Transition Form. Resident #4's Physician Orders and Physician Notes documented that she would be discharged home on 2/25/18 with Home Health services. The physician signed the order for discharge on 2/23/18.	F 661	F661 Discharge Summary 1. Resident #3 and Resident #4 no longer reside in this facility. 2 All discharging residents have the potential to be affected by a deficient practice in this area. Beginning on or before July 31, 2018 discharging patients and their continuum providers have been given discharge information in accordance with CFR 483.15(c)(1)(i)(ii)(2)(i)-(iii). 3 On or before July 31, 2018 education was provided to the Interdisciplinary Team by the corporate Director of Clinical Operations and facility Director of Nursing on discharge packets and required information under CFR 483.15(c)(1)(i)(ii)(2)(i)-(iii). 4 Beginning August 1, 2018 Discharge Packets will be reviewed by the Director of Nursing or designee weekly for 4 weeks; every two weeks for 4 weeks; then monthly to ensure that the packet is completed before discharge. Results of these audits will be provided monthly to the facility□'s QAA committee. Any identified problems will be addressed by Root Cause Analysis and Performance Improvement Plan until 100% compliance is achieved.	

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F 661	Continued From page 16 The Discharge and Transition Form, dated 2/13/18, documented Resident #4 was discharged on 2/25/18. The form did not include information of a physician's visit scheduled following discharge from the facility and it was not signed by the resident or resident representative as reviewed during discharge. The form was not signed by the discharge RN. There was no documentation regarding Resident #4's course of treatment in the facility regarding her CPR event. There was no discharge summary documentation in Resident #4's medical record. There was no documentation of a recapitulation of the resident's stay, final summary of the resident status, reconciliation of medications prior to discharge, post-discharge plan of care, or documentation the facility provided a discharge summary and other pertinent information to the home health agency. On 6/29/18 at 3:56 PM, the DNS stated the information previously provided was all the information she could find regarding Resident #4's discharge. 2. Resident #3's admission record dated 1/31/18 and a readmission record of 2/18/18, included diagnoses of orthopedic aftercare, difficulty in walking, muscle weakness, cognitive communication deficit, traumatic subdural hematoma (collection of blood outside the brain), bradycardia (slower than normal heart rate), Parkinson's disease, and major depressive disorder.	F 661		

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F 661	Continued From page 17 Resident #3's discharge packet documented she was discharge on 2/27/18. The discharge packet (summary) did not include Resident #3's advance directive information, comprehensive care plan goals, recapitulation of her stay, and a post discharge plan of care. In an interview on 6/29/18 at 3:55 PM, the DNS stated no further information was available regarding Resident #3's discharge.	F 661		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN – Director

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June 11, 2019

Richard Strong, Administrator
Riverview Rehabilitation
3550 West Americana Terrace
Boise, ID 83706-4728

Provider #: 135139

Dear Mr. Strong:

On **June 29, 2018**, an unannounced on-site complaint survey was conducted at Riverview Rehabilitation. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007763

ALLEGATION

The facility discharged a resident before they where ready and charged the family for costs when they should not have.

FINDINGS:

During the investigation two residents were observed and four residents' records, which included two closed records, were reviewed for discharge planning. Multiple interviews were conducted with residents and family members. Multiple staff members were interviewed regarding the discharge process. Facility grievances and Resident Council minutes were reviewed.

Four of Four residents' records documented concerns with the discharge process to include failure of the facility to ensure residents were not charged for services required to meet the needs for residents, failure to ensure the Admission Packet fully informed residents, prior to, or at the time of admission, of their transfer and discharge rights, failure to ensure residents were provided advance notice of the reason their Medicare Coverage was being terminated during their stay in

the SNF and how to appeal the termination process, failure to ensure all the discharge information was provided to the receiving care agency, and failure to ensure appropriate information was documented in the resident's record and provided to the receiving health care provider upon discharge.

Grievances and Resident Council meeting minutes were reviewed and documented concerns with the discharge process and verbalized the social worker was not helpful throughout the process.

Several residents and family members stated they had concerns with the facility's discharge process.

Several staff members interviewed described the discharge process and did not realize they were not meeting the regulations.

Based on the investigative findings, the allegation was substantiated. Deficiencies were cited at F571, F572, F582, F622, and F661 as they related to the failure of the facility to ensure residents' discharge planning was appropriate, they were not charged for services, information was sent with the resident to other agencies, appropriate knowledge of residents appeals process, and the admission packet fully informed the residents of the transfer and discharge process.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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