



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

July 24, 2018

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

Provider #: 135068

Dear Mr. Lewis, Jr.:

On **July 11, 2018**, a survey was conducted at Parke View Rehabilitation & Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

Corwin Lewis, Jr., Administrator  
July 24, 2018  
Page 2

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 **August 3, 2018**. Failure to submit an acceptable PoC by **August 3, 2018**, may result in the imposition of penalties by **August 26, 2018**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

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

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **August 15, 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 **October 9, 2018**. A change in the seriousness of the deficiencies on **August 25, 2018**, may result in a

Corwin Lewis, Jr., Administrator  
July 24, 2018  
Page 3

change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 11, 2018** includes the following:

Denial of payment for new admissions effective **October 11, 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 **January 11, 2019**, 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 **October 11, 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:

Corwin Lewis, Jr., Administrator  
July 24, 2018  
Page 4

<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:

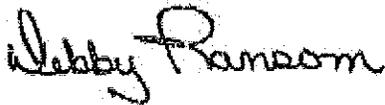
- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)  
[2001-10 IDR Request Form](#)

This request must be received by **August 3, 2018**. If your request for informal dispute resolution is received after **August 3, 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/

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

PRINTED: 07/24/2018  
FORM APPROVED  
OMB NO. 0938-0391

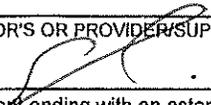
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/11/2018
NAME OF PROVIDER OR SUPPLIER  PARKE VIEW REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  The following deficiencies were cited during the complaint survey of the facility. The survey team entered and exited the facility on July 11, 2018.  The surveyors were:  Edith Cecil, RN Suzy Devereaux, BSN, RN  Abbreviations:  CNA = Certified Nursing Assistant CT = Computerized Axial Tomography (X-ray tests that produce cross-sectional images of the body using X-rays and a computer) DON = Director of Nursing mg = milligram RN = Registered Nurse	F 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Parke View Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656	1. Resident #3 had missing items within the resident comprehensive care plan. 2. All residents who use a Hoyer lift have the potential to be affected. 3. Education provided to IDT and LNs. IDT will review and update care plans for Comprehensive Assessments. 4. DNS/designee will audit implementation of care plans for Hoyer sling size weekly times 4 weeks and then monthly times 3 months. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.	8/10/18

RECEIVED  
AUG - 6 2018  
FACILITY STANDARDS

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

TITLE

(X6) DATE

 ADMINISTRATOR 8/3/18

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.

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

PRINTED: 07/24/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/11/2018
NAME OF PROVIDER OR SUPPLIER  PARKE VIEW REHABILITATION & CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	<p>Continued From page 1</p> <p>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> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure comprehensive resident centered care plans included the use of mechanical lift slings used for mechanical lift transfers. This was true for 1 of 1 resident (#3) reviewed who required the use of a mechanical lift. This deficient practice placed the resident at risk of falling from the mechanical lift during transfers or other injuries if the sling used was the wrong size for the resident. Findings include:</p> <p>The facility's Policy/Procedure for mechanical lift</p>	F 656		

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

PRINTED: 07/24/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/11/2018
NAME OF PROVIDER OR SUPPLIER  PARKE VIEW REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 656	Continued From page 2 sheet, dated 5/4/18, documented the following:  a. It is the policy of this facility that all residents that require Mechanical Lift will use the appropriate lift and sheet size (sling.) The sheet size will be determined by Therapy and or Restorative Nurse or designee. b. The sheet size is determined by the resident's size and assessment of the resident during the transfers. c. The care plan will be updated to determine correct lift and sheet size.  Resident #3 was admitted to the facility on 5/15/15 with multiple diagnoses, which included cerebral infarct (stroke) and unspecified dementia.  A quarterly Minimum Data Set (MDS) assessment, dated 2/8/18, documented Resident #3 had moderately impaired cognition, impaired range of motion to upper and lower extremities, and was dependent upon 2 plus staff for transfers.  Resident #3's Care Plan, dated 1/18/17 documented she required a Hoyer lift with the assistance of 2 staff for transfers. The Care Plan did not specify the use of a sheet/sling.  On 7/11/18 at 11:30 AM, the DON stated Therapy and RN #1 should have assessed Resident #3 to determine the size of the sling and placed the information on the care plan.	F 656			
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c)  §483.35 Nursing Services	F 726	1. Written Counseling given to CNA involved in Resident #3 incident. 2. All residents care planned for use of Hoyer Lift can be affected by this practice.	8/10/18	

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

PRINTED: 07/24/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/11/2018
NAME OF PROVIDER OR SUPPLIER  PARKE VIEW REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 726	<p>Continued From page 3</p> <p>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).</p> <p>§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.</p> <p>§483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, review of the Hoyer lift Operations Manual, and facility policy review, it was determined the facility failed to ensure staff applied Hoyer (mechanical) lift sling straps correctly. This was true for 1 of 1 (#3) resident reviewed who required the use of a mechanical lift. As a result, Resident #3 slipped out of the sling during a transfer, landed on her</p>	F 726	<p>3. Policies updated for mechanical Hoyer lift and Nursing staff competency. Education provided to CNAs related to Hoyer Lift Manual and competency test done.</p> <p>4. DNS or designee will perform 5 Hoyer lift competency audits weekly for 4 weeks and monthly for 3 months. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.</p>		

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

PRINTED: 07/24/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/11/2018
NAME OF PROVIDER OR SUPPLIER  PARKE VIEW REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 726	<p>Continued From page 4</p> <p>head, and sustained a scalp hematoma (solid swelling of clotted blood in tissue). Findings include:</p> <p>Resident #3 was admitted to the facility on 5/15/15 with multiple diagnoses, which included cerebral infarct (stroke) and unspecified dementia.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 2/8/18, documented Resident #3 had moderately impaired cognition, impaired range of motion to upper and lower extremities, and was dependent upon 2 plus staff for transfers.</p> <p>A Care Plan, dated 1/18/17, documented Resident #3 required a Hoyer lift with the assistance of 2 staff for transfers. The Care Plan did not specify the use of a sheet/sling.</p> <p>The facility's Mechanical Lift (Hoyer brand) Policy, revised 5/2007, documented:</p> <ul style="list-style-type: none"> <li>* Procedure to be performed by nursing assistants or licensed nurses who have been instructed on use of the device.</li> <li>* The patient should be elevated high enough to clear the transfer surface with their weight fully supported by the lift.</li> <li>* When the patient is clear of the transfer surface, swing their feet clear of the transfer surface.</li> </ul> <p>The facility's policy did not direct nursing staff to check the sling straps to ensure the straps were securely attached to the swivel bar prior to moving the seat or resident.</p> <p>The facility's Nursing Staff Competency policy,</p>	F 726			

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

PRINTED: 07/24/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/11/2018
NAME OF PROVIDER OR SUPPLIER  PARKE VIEW REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 726	<p>Continued From page 5</p> <p>revised 9/2007, documented it was the policy of the facility to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety. The policy listed skills and competencies necessary to care for residents needs. The list did not include competency in the use of mechanical transfer devices.</p> <p>The facility's Fall Scene Investigation Report, dated 5/1/18 at 11:10 AM, documented an incident which involved Resident #3, CNA #1, and a CNA student, as follows:</p> <p>"Resident #3 requested to lie down, staff in room, Resident in Hoyer sheet. Sheet hooked up right corner came loose, Resident slid out of Hoyer sheet to floor, lower body hit foot pedals-head hit floor, hematoma felt. CNA did have a CNA student with her. The root cause of the fall was documented as "strap on Hoyer sheet for top was not placed on the hooks correctly causing Resident to slide forward and out of sling. (The sling rests under the resident, loop/straps on four corners are placed on the hooks of the swivel bar which then pull the resident up.)</p> <p>A nursing progress note, dated 5/2/18 at 10:14 AM, documented Resident #3 was transferred to the emergency room (ER) on 5/1/18 at 11:40 AM via ambulance.</p> <p>The ER Visit Note, dated 5/1/18 at 2:00 PM, documented Resident #3 was dropped during a transfer and hit the vortex (top) of her head on the ground or some other surface. The ER Visit Note documented Resident #3 did not have a loss of consciousness, was negative for mental status changes, and was positive for a hematoma. The</p>	F 726			

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

PRINTED: 07/24/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/11/2018
NAME OF PROVIDER OR SUPPLIER  PARKE VIEW REHABILITATION & CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	<p>Continued From page 6</p> <p>ER Visit Note documented Resident #3's medication list included Clopidogrel 75 mg (Plavix - medication to prevent blood clots).</p> <p>A CT scan was completed with a final report, dated 5/1/18 at 1:19 PM, which documented there was no evidence of acute intracranial hemorrhage, midline shift, or mass effect. There was a right vertex scalp hematoma without evidence of skull fracture.</p> <p>The ER report documented the impressions as:</p> <ul style="list-style-type: none"> <li>* Right vertex scalp hematoma without evidence of underlying skull fracture or acute intracranial injury.</li> <li>* Unchanged CT appearance of the head without evidence of an acute intracranial process as described.</li> </ul> <p>The ER Visit Note documented Resident #3 experienced an accidental fall during a transfer which resulted in scalp hematoma. The note stated the CT of Resident #3's head was normal and she was back to her baseline status. Resident #3 was discharged back to the facility in stable condition with instructions to follow up with her primary care provider if she was not improving.</p> <p>A nursing progress note, dated 5/1/18 at 5:40 PM, documented Resident #3 returned from the ER with Patient Care Instructions for an adult head injury and no new orders.</p> <p>Resident #3's Neurological Check Sheet, dated 5/1/18 - 5/3/18, documented she opened eyes spontaneously, remained oriented, and obeyed commands.</p>	F 726		

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

PRINTED: 07/24/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/11/2018
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  PARKE VIEW REHABILITATION & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 726	Continued From page 7  A documented interview with CNA #1 was completed by the DON on 5/1/18. In the interview CNA #1 stated she and the CNA student were transferring Resident #3 from the wheelchair to the bed using the Hoyer lift. As they lifted her from the wheelchair, the top right strap came unhooked which left an opening in the upper right and Resident #3 came out head first falling backward hitting the top of her head. CNA #1 stated she did not remember doing anything differently with the set-up with this transfer and did not know how the strap came off the Hoyer lift.  A facility Skills Checklist - Nursing Assistant Certified form, dated 6/14/17, was provided for documentation of training CNA #1 completed. The Skills Checklist included Safe Use of Mechanical Lifts and Assistive Devices for transfers.  On 5/1/18, the facility completed Education Counseling Documentation for CNA #1. The form directed CNA #1 to make sure all straps are fully connected properly around the loop prior to lifting a resident, to always have 2 staff members for Hoyer transfers, and the students do not count as the second person moving forward related to Hoyer lift transfers. This education was signed by CNA #1.  On 5/8/18, CNA #1 completed the Skills Checklist-Nursing Assistant Certified for Safe Use of Mechanical Lifts and Assistive Devices.  The DON completed an interview with the CNA student on 5/1/18. The DON documented the CNA student stated CNA #1 connected the straps	F 726		
-------	---	-------	--	--

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

PRINTED: 07/24/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/11/2018
NAME OF PROVIDER OR SUPPLIER  PARKE VIEW REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 726	<p>Continued From page 8 to the lift. The CNA student stated the incident happened very quickly.</p> <p>A Final Skills Checklist was provided on 7/12/18, which documented the CNA student demonstrated competency in transferring using a mechanical lift on 4/11/18 in the lab setting and 4/27/18 in the clinical setting.</p> <p>On 7/11/18 at 1:17 PM, the DON provided the Operations manual for the Hoyer mechanical lift. The Hoyer lift manual for operation provided instructions/warnings on each page. Relevant to transfers:</p> <p>a. When elevated a few inches off the surface of the bed and before moving the patient, check again to make sure that the sling is properly connected to the hooks of the swivel bar. If any attachments are NOT properly in place, lower the patient back onto the bed and correct this problem. Adjustments for safety and comfort should be made before moving the patient. Invacare slings are made specifically for use with Invacare Patient Lifts. For the safety of the patient, DO NOT intermix slings and patient lifts of different manufacturers.</p> <p>b. Be sure to check the sling attachments each time the sling is removed and replaced to ensure that it is properly attached before the patient is removed from the bed or chair.</p> <p>On 7/11/18 at 1:17 PM, the DON stated that prior to 5/1/18, the CNA staff demonstrated how to use the mechanical lifts. The DON stated that on 5/1/18, nursing staff were provided the Hoyer lift manual for operation instructions/warnings. The nursing staff were directed to read, sign, and date</p>	F 726			

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

PRINTED: 07/24/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  D. WING _____		(X3) DATE SURVEY COMPLETED  C 07/11/2018
NAME OF PROVIDER OR SUPPLIER  PARKE VIEW REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 726	Continued From page 9 when each completed reading the manual. The facility provided 42 signatures, CNA #1 and the CNA student were not on the list of signatures.  On 7/11/18 at 1:40 PM, CNA #1 stated the day of the incident, there was another staff CNA with her and the CNA student but the staff CNA left the room prior to transferring Resident #3. CNA #1 stated she placed the straps on one side of the swivel bar and the student placed the straps on the other side. CNA #1 did not remember who placed which side. CNA #1 stated she guided the Hoyer lift and the CNA student moved the wheelchair. CNA #1 stated she had not completed raising the lift, it was pretty close to one foot above the wheelchair seat. CNA #1 stated she completed Hoyer lift demonstrations following the incident. CNA #1 stated she did not remember receiving education on the Hoyer lift operation manual after the incident and not recently. CNA #1 stated she did not receive direction from the facility prior to working with the CNA students. CNA #1 stated initially, the CNA program instructors would inform the staff CNA what the students could do, but after a while, the instructors said to let them get their hands dirty.	F 726			



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

February 25, 2019

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

Provider #: 135068

Dear Mr. Lewis, Jr.:

On **July 11, 2018**, an unannounced on-site complaint survey was conducted at Parke View Rehabilitation & Care Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007844**

**ALLEGATION #1:**

A resident slipped out of a sheet/sling during a mechanical lift transfer because the straps were not properly placed.

**FINDINGS #1:**

During the investigation, observations of staff completing mechanical lift transfers were made, one resident interview was completed, and five staff interviews were conducted. Resident records were reviewed, policies were reviewed, the mechanical lift operations manual was reviewed, Incident and Accident reports and facility investigations were reviewed, and Certified Nursing Assistant (CNA) employee files were reviewed.

Three residents were observed as CNAs used a mechanical lift to complete transfers. The sheet/slings were attached appropriately and the residents were transferred safely.

The facility's Mechanical Lift (Hoyer brand) Policy, revised 5/2007, documented:

- Procedure to be performed by nursing assistants or licensed nurses who have been instructed on use of the device.
- The patient should be elevated high enough to clear the transfer surface with their weight fully supported by the lift.
- When the patient is clear of the transfer surface, swing their feet clear of the transfer surface.

The facility's policy did not direct nursing staff to check the sling straps to ensure the straps were securely attached to the swivel bar prior to moving the seat or resident.

The operations manual for the Hoyer mechanical lift was reviewed. The manual provided warnings in relation to lifting the patient on multiple pages. The manual documented when elevated a few inches off the surface of the bed and before moving the patient, check again to make sure that the sling is properly connected to the hooks of the swivel bar. If any attachments are not properly in place, lower the patient back onto the bed and correct this problem. Adjustments for safety and comfort should be made before moving the patient. Invacare slings are made specifically for use with Invacare Patient Lifts. For the safety of the patient, do not intermix slings and patient lifts of different manufacturers. The manual also documented to be sure to check the sling attachments each time the sling is removed and replaced to ensure that it is properly attached before the patient is removed from the bed or chair.

An investigation report documented an incident in which a resident slid out of the sling onto the floor and hit her head. The CNA and a CNA student were the staff who attempted to transfer the patient using the mechanical lift.

The facility's inservice and training records for CNAs were reviewed. The DON stated prior to 5/1/18, the CNA staff demonstrated how to use the mechanical lifts. The DON stated on 5/1/18, nursing staff were provided the Hoyer lift manual for operation instructions/warnings. The nursing staff were directed to read, sign, and date when each completed reading the manual. The facility provided 42 signatures. The CNA and the CNA student were not on the list of signatures.

Based on the investigative findings, the facility was cited at F726 as it relates to the failure of the facility to ensure staff were competent to safely transfer residents using a Hoyer mechanical lift.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

#### ALLEGATION #2:

The facility does not notify family when the resident has a decline in health status.

#### FINDINGS #2:

Corwin Lewis, Jr., Administrator  
February 25, 2019  
Page 3 of 3

During the investigation observations and two staff interviews were conducted. Records, including three resident records, were reviewed.

A resident's record included a nurse's note, which documented the staff observed a change in the resident's condition. The staff received a physician's order to transfer the resident to the hospital via non-emergent ambulance. The staff called 911 for non-emergent transport and the family was notified a minute later. Family requested the facility call them back when the resident was on her way to the emergency room. The resident left the facility via ambulance at and family was notified when she left.

The resident was diagnosed with acute blood loss secondary to an acute upper gastrointestinal bleed, acute renal failure, altered mental status secondary to the above, pneumonia, and a urinary tract infection. An Emergency Room Visit Note, a History and Physical from the acute care facility, and the Discharge Summary from the acute care facility documented the family was informed of medical diagnoses and treatment choices, and directed the treatment the acute care facility provided and the withdrawal of treatment. "The family is aware of what comfort measures means."

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