



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P. O. Box 83720
Boise, Idaho 83720-0009
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December 24, 2018

Cindy Riedel, Administrator
Bridgeview Estates
1828 Bridgeview Boulevard,
Twin Falls, ID 83301-3051

Provider #: 135113

Dear Ms. Riedel:

On **December 3, 2018**, a survey was conducted at Bridgeview Estates 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 actual 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.) **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 **January 3, 2019**. Failure to submit an acceptable PoC by **January 3, 2019**, may result in the imposition of civil monetary penalties by **January 26, 2019**.

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*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy(ies):

Civil Money Penalty

Denial of payment for new admissions effective March 3, 2019

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 3, 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.

Cindy Riedel, Administrator
December 24, 2018
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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.

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>

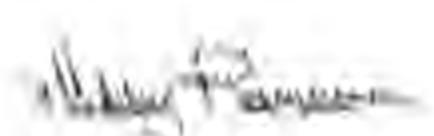
go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- 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 **January 3, 2019**. If your request for informal dispute resolution is received after **January 3, 2019**, 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: 01/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2018
NAME OF PROVIDER OR SUPPLIER BRIDGEVIEW ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301		
(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 unannounced federal recertification and complaint investigation survey of the facility. The survey team entered the facility November 26, 2018 and exited with the facility on December 3, 2018. The surveyors were: Linda Kelly, RN, Team Coordinator Wendi Gonzales, RN Kathryn Davis, RN Geri Wolfe, RN Abbreviations: ADL = Activities of Daily Living BLE = bilateral lower extremities cc = cubic centimeter CSD = Central Supply Director DON = Director of Nursing DOR = Director of Rehabilitation LPN = Licensed Practical Nurse LSW = Licensed Social Worker MAR = Medical Administration Record MDS = Minimum Data Set mg = milligram NA = Nursing Assistant P&P = Policy and Procedure PRN = when necessary RDCCS = Regional Director of Clinical Services RSD = Resident Services Director SOB = Shortness of Breath SLP = Speech Language Pathologist tsp = teaspoon UCC = Unit Care Coordinator	F 000			
F 550	Resident Rights/Exercise of Rights	F 550			1/16/19

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

TITLE

(X6) DATE

Electronically Signed

01/03/2019

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 550 SS=D	Continued From page 1 CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her	F 550			

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F 550	<p>Continued From page 2</p> <p>rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, observation, resident interview, and staff interview, it was determined the facility failed to ensure the dignity of the residents was maintained. This was true for 2 of 3 residents (#16 and #50) who wore wrist bands and were reviewed for dignity. This failure created the potential for psychosocial harm and well-being should resident's self-worth and self-esteem be negatively affected. Findings include:</p> <p>The facility's policy Ready, Set, Go! Rehabilitation Program, undated, documented all residents on rehabilitation services will be given a colored wrist band when they are initially evaluated by therapy. These wrist bands will help all staff know what level of assistance to provide for residents during their stay at the facility. As residents progress in their therapy, their wrist bands will be changed by therapy staff. A red wrist band indicates residents are only walking with therapy staff and all transfers require assistance from a staff member. A yellow band indicates residents can walk with staff members in their room and within the facility. They may need assistance with a walker, cane, or crutches. These residents must have staff with them if they are walking or transferring. A green wrist band indicates residents can walk independently in their room and in the facility without assistance from staff.</p> <p>1. Resident #16 was readmitted to the facility on</p>	F 550	<p>The facility will ensure the dignity of the resident is maintained.</p> <p>The facility staff removed the wristbands from Resident #16 and Resident #50 with their permission.</p> <p>Residents who participated in the therapy department had the potential to be affected. All residents were visited and all wristbands were removed with permission of the resident. Staff were in serviced on the new way that therapy will communicate safety issues of the resident. The wristband of the Ready, Set, Go has been discontinued.</p> <p>In order to effectively communicate therapy recommendations with staff members, therapy will complete a Care Plan at initial evaluation and with any notable functional changes. The Care Plan will be given to the RCM who will update the nursing documentation.</p> <p>Ed/or designee will audit to assure compliance.</p> <p>Audits to assure no resident is wearing wrist bands will be completed weekly X4 then Monthly X 2.</p> <p>Results will be reported to QAPI</p>		

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F 550	<p>Continued From page 3</p> <p>9/5/18, with multiple diagnoses including history of transient ischemic attack (a brief episode of neurological dysfunction), cerebral infarction (stroke), difficulty walking, generalized muscle weakness, unsteadiness, gait and mobility abnormalities, and repeated falls.</p> <p>Resident #16's physical therapy notes, dated 8/3/18, documented he was issued and educated regarding the red wrist band. Resident #16 was agreeable for staff to assist with all mobility.</p> <p>Resident #16's significant change MDS assessment, dated 9/12/18, documented his cognition was intact, and family or significant other participated in the assessment. The MDS assessment documented Resident #16's functional status required one and two person assist with ADLs, and a history of falls.</p> <p>On 11/27/18 at 9:47 AM, Resident #16 was observed in his room sitting in his wheelchair watching television. Resident #16 was observed with a red wrist band on his left arm. At that time, Resident #16 stated he had the red wrist band on his arm because he had a history of falling and would rather not have to wear the wrist band.</p> <p>On 11/30/18 at 10:53 AM, the DOR stated she had been here since June 2018. The DOR stated the Ready, Set, Go! Program had been used by the facility for awhile and the residents usually really liked the program. The DOR stated the resident may refuse to use the wrist band. The DOR stated she did not know Resident #16 still had a wrist band and was no longer on Rehab. The DOR stated the bands were used to communicate between physical therapy and</p>	F 550	<p>Committee meeting monthly for 3 months for review and remedial intervention. Ed/or Designee is responsible for monitoring and compliance .</p> <p>The QAPI Committee will re-evaluate need for further monitoring after 3 months.</p> <p>As of December 10, 2018 wristbands are no longer available in the therapy department</p>		

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F 550	<p>Continued From page 4 nursing staff.</p> <p>2. Resident #50 was admitted to the facility on 11/7/18, with multiple diagnoses including generalized muscle weakness.</p> <p>Resident #50's care plan, dated 11/8/18, directed staff to provide extensive one to two person assistance with transfers, mobility, and ambulation in therapy.</p> <p>Resident #50's admission MDS assessment, dated 11/14/18, documented his cognition was moderately impaired, and family or significant other participated in the assessment. The MDS assessment documented Resident #50's functional status required one and two person assistance with ADLs.</p> <p>Resident #50's care plan conference, dated 11/19/18, documented he was not making much progress, and there was concern for potential for injury. Resident #50's care plan conference did not address applying a wrist band.</p> <p>On 11/26/18 at 6:53 PM, Resident #50 was observed in his room lying in bed with his wife present. Resident #50 was observed with a red wrist band on his left arm. Resident #50 stated the red band on his left wrist was not something he wanted to wear by choice.</p> <p>On 11/29/18 at 11:37 AM, LPN #4 stated Resident #50's wrist band was for the staff and resident to know if residents were able to move independently. The green wrist band was for independent, red was for assistance needed, and yellow was for a fall risk. LPN #4 stated residents</p>	F 550			

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F 550	Continued From page 5 could refuse to have the wrist band in place and it should be care planned. On 11/29/18 at 3:12 PM, the Administrator stated she did not know any residents in the facility were wearing wrist bands, except one that had a green wrist band, and she did not know that the residents did not want to wear the wrist bands. The Administrator also stated for the residents who received physical therapy and wore wrist bands, it gave the residents something to celebrate when they achieved the green wrist band.	F 550			
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.	F 553		1/16/19	

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F 553	<p>Continued From page 6</p> <p>§483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-</p> <p>(i) Facilitate the inclusion of the resident and/or resident representative.</p> <p>(ii) Include an assessment of the resident's strengths and needs.</p> <p>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident interview, staff interview, and record review, it was determined the facility failed to ensure residents were provided the opportunity to participate in the care planning process for the development and implementation of their person-centered plan of care. This was true for 1 of 24 residents (Resident #49) who were reviewed for care planning. The failure created the potential for harm if residents' care was provided inconsistent with their needs and preferences. Findings include:</p> <p>Resident #49 was admitted to the facility on 11/21/17, with multiple diagnoses including atrial fibrillation (an irregular heart rhythm). He was readmitted on 10/25/18, following a brief hospitalization related to the atrial fibrillation and had a coronary angioplasty with stent placement. An angioplasty is a minimally invasive procedure to unblock arteries.</p> <p>Resident #49's annual MDS assessments, dated 11/13/18, documented his hearing and vision were adequate and his speech was clear, he understood others and they understood him, and he was independent in cognitive skills for daily</p>	F 553	<p>The Facility will ensure residents are provided the opportunity to participate in the care planning process for the development and implementation of their person-centered plan of care.</p> <p>Resident #49 attended a Care Plan Conference on December 27, 2018.</p> <p>Current residents have the potential to be affected by the practice.</p> <p>An audit of all current residents was completed. Current Residents who did not attend a care conference in the last quarter were provided the opportunity to attend a care conference. Documentation was provided in the medical records of the residents who preferred not to attend.</p> <p>ED/or designee will audit the care conferences provided weekly x 4 weeks then monthly x 2 Results will be reported to the QAPI Committee. ED is responsible for the monitoring and</p>		

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F 553	Continued From page 7 decision making. On 11/27/18 at 9:54 AM, Resident #49 said he had not participated in any care planning or care conference meetings. There was no documentation of care planning/conference meetings in Resident #49's record. On 11/29/18 at 5:48 PM, the RSD said there were no care conferences for Resident #49 since he was admitted in 2017.	F 553	compliance The QAPI committee will re-evaluate the need for further monitoring after 3 months .		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §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. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (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. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 578		1/16/19	

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F 578	<p>Continued From page 8</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:</p> <p>Based on staff interview, record review, review of the facility's Admission packet, and policy review, it was determined the facility failed to ensure residents were provided written information regarding Advance Directives in a language they could understand and assisted them to formulate Advance Directives. This was true for 1 of 24 residents (Resident #1) who were reviewed for Advance Directives. The failure increased the risk Resident #1's health care preferences would not be honored if she became incapacitated and unable to communicate her wishes. Findings include:</p> <p>The facility's Advance Directives policy, dated 2/2018, documented "The resident has a right to execute or refuse to execute an advance directive, which stipulates how decisions regarding his or her medical care are made.</p>	F 578	<p>The facility will ensure the residents are provided written information regarding Advance Directives in a language they can understand and will assist them to formulate Advance Directives.</p> <p>Resident #1 was provided an Advance Directive in Spanish and was assisted in formulating a Advance Directive.</p> <p>Residents who speak a language other than English would have the potential to be affected by the practice.</p> <p>Advance Directives will be provided in the language the resident may understand. An interpreter is available, if needed to assist the non speaking English residents of information on the</p>		

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F 578	<p>Continued From page 9</p> <p>Residents have the right to self-determination regarding their medical care. This includes...to direct his or her own medical treatment, including withholding or withdrawing life sustaining treatment."</p> <p>The State Operations Manual defined an "Advance directive" is 'a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.'" "Physician Orders for Life-Sustaining Treatment (or POLST) paradigm form" is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST paradigm form is not an advance directive."</p> <p>Resident #1 was admitted to the facility on 5/4/18, with multiple diagnoses including a pelvic fracture, generalized muscle weakness, acute kidney failure, and major depressive disorder.</p> <p>Resident #1's quarterly MDS assessments, dated 8/22/18, documented her preferred language was Spanish and she needed or wanted an interpreter to communicate with health care staff and the physician. She understood others and they understood her and her cognition was modified independent (some difficulty in new situations only).</p> <p>Resident #1's Baseline Care Plan and Initial</p>	F 578	<p>advance directive.</p> <p>An audit was completed on all current residents concerning their advance directives. All residents who wished to have advance directives in their medical records were reviewed again. Any resident who did not want advance directive in their medical records were re educated and documented in their medical record.</p> <p>Each resident will have the advance directive reviewed each quarterly care conference and PRN. Education on the advance directive will be documented each quarter .</p> <p>ED/ or designee will audit the new admissions for advance directive acknowledgement/ and or the advance directive in place . Audits will be completed weekly x 4 then monthly x 2.</p> <p>Results will be reported to the QAPI Committee monthly for 3 months for review and remedial interventions. The QAPI Committee will re-evaluate the need for further monitoring after 3 months .</p>		

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F 578	<p>Continued From page 10</p> <p>Discharge Plan, dated 5/24/18, documented her Advance Directive was "DNR (Do Not Resuscitate)."</p> <p>Resident #1's comprehensive care plan for Advance Directives, dated 5/24/18, also documented was a DNR. The care plan also stated her sons will make all health care decisions if she became incapacitated.</p> <p>Resident #1's record included a POST form that documented she was a DNR and wanted limited additional interventions of intravenous (IV) fluids, antibiotics, and blood products. She signed the POST on 5/14/18, and the physician signed it on 5/29/18. No other Advance Directive information was found in Resident #1's record.</p> <p>A Progress Note by the LSW, dated 11/5/18, documented "In looking through [Resident #1's name] chart noted she does not have a living will or DPOA [Durable Power of Attorney] for healthcare, and her family states she has not filled one out before. SW [Social Worker] sent email to Office on Aging inquiring about if they have these documents in Spanish for resident to look at in case she would like to fill one out. Awaiting to hear back from them." There were no other Social Service notes.</p> <p>On 11/28/18 at 3:13 PM, the LSW said she contacted the Office on Aging on 11/5/18 to request Advance Directive information in Spanish and she received it the next day. She said she called Resident #1's son soon after that and told him she received the Advance Directive information in Spanish. The LSW said she did not document the conversation with Resident #1's</p>	F 578			

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F 578	Continued From page 11 son and she did not talk with Resident #1. She said the son lived and worked in another town and he had not been back to the facility "in awhile." The LSW said Resident #1 was interviewable and she could have talked to her with a Spanish speaking staff member to interpret.	F 578			
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;	F 622		1/16/19	

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F 622	Continued From page 12 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 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	F 622			

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F 622	<p>Continued From page 13 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 contact information</p> <p>(C) Advance Directive information</p> <p>(D) All special instructions or precautions for ongoing care, as appropriate.</p> <p>(E) Comprehensive care plan goals;</p> <p>(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 record review, staff interview, home health provider staff interview, resident representative interview, it was determined the facility failed to ensure appropriate information was communicated to a home health care provider upon the discharge of a resident. This was true for 1 of 5 residents (Resident #157) who were reviewed for discharge from the facility. The deficient practice created the potential for harm if home health services were not provided as ordered for the resident. Findings include:</p> <p>Resident #157 was admitted to the facility on 1/21/17 and readmitted on 3/21/17, with multiple diagnoses including Lewy Body dementia (abnormal protein deposits), congestive heart failure, chronic pain, abnormalities of gait and mobility, muscle weakness, dysphagia (difficulty swallowing), and severe protein-calorie malnutrition.</p>	F 622	<p>The facility will ensure that appropriate information is communicated to the home health care provider upon discharge of the resident.</p> <p>Resident # 157 was discharged home on 4-15-17.</p> <p>All discharging residents have the potential to be affected by the discharging practice.</p> <p>Audits will be completed on discharged residents to ensure their Home Health Agency was contacted and in place.</p> <p>1. LSW/RCM will maintain the fax confirmation sent to the Home Health Agencies .If given by hand to the Agency . LSW/RCM will chart it in the</p>		

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F 622	Continued From page 14 A physician's order, dated 4/14/17, documented "May discharge home with home health physical therapy [PT], occupational therapy [OT], and nursing." Resident #157's Discharge Summary, dated 4/15/17, documented she was returning home with home health services per her request. Resident #157's Initial Discharge Planning record, dated 1/23/17, documented she had previously used in-home care and services from an agency. It was the same home health care provider documented in the Discharge Summary. A social services progress note, dated 4/19/17, by the RSD documented Resident #157 was discharged to home on 4/15/17, she worked with PT, OT, and speech therapy during her stay in the facility, and she met all of her goals for discharge. A home evaluation was completed prior to discharge, tube feedings were discontinued and, the RSD documented home health was arranged following discharge of Resident #157. On 11/29/18 at 5:28 PM, the RSD said she asked residents if they received home health care in the past and which agency provided the care. She said she normally sent a face sheet, History and Physical by the physician, the MARs and TARS, physician orders, including the discharge order, and the last physician visit note by fax to the home health provider. When asked how she knew the home health provider received the referral information for Resident #157, the RSD said she watched the fax machine	F 622	medical record . 2. Facility will invite the Home Health Agency into the last Care Conference of the discharging resident for a smooth transition, with permission of the resident. 3. Sunshine calls will be made to the resident to assure that home health agency are in place in the home after discharge, within 24/48 hours after discharge. ED/or designee will audit the discharges. Audits will be completed weekly x 4 then monthly X 2 . Results will be reported to the QAPI Committee monthly for 3 months for review and remedial interventions. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.		

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F 622	Continued From page 15 to see the confirmation page but she did not retain the fax confirmation. The RSD reviewed Resident #157's clinical record and said she did not document what she faxed to the home health provider and there were no copies of what she faxed to the home health care provider in the record. The RSD said she did not find documentation she communicated by phone or in person with the home health provider. On 11/30/18 at 11:58 AM, the Business Manager of the home health care provider said they did not receive any referral information for Resident #157 in 2017. The Business Manager said all referrals for their home health services went through the business office and they kept all referral information whether the person was admitted or not. She said the last time the home health care provider received a referral for Resident #157 was in 2016. On 11/30/18 at 3:53 PM, Resident #157's representative said home health care was not provided after her discharge from the facility on 4/15/17, and she was hospitalized 10 days later. The representative said she contacted the home health care provider later and they said they never received any referral information in April 2017.	F 622			
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide	F 655			1/16/19

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F 655	<p>Continued From page 16</p> <p>effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-</p> <p>(i) Be developed within 48 hours of a resident's admission.</p> <p>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-</p> <p>(A) Initial goals based on admission orders.</p> <p>(B) Physician orders.</p> <p>(C) Dietary orders.</p> <p>(D) Therapy services.</p> <p>(E) Social services.</p> <p>(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.</p> <p>(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.</p> <p>(ii) A summary of the resident's medications and dietary instructions.</p> <p>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.</p> <p>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 655			

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F 655	<p>Continued From page 17</p> <p>Based on observation, resident interview, staff interview, and record review, it was determined the facility failed to ensure the baseline care plan included communication as a potential barrier for 1 of 3 residents (Resident #1) who were non-English speaking and who were reviewed. The failure created the potential for harm if the care and services provided did not meet her needs or was contrary to her wishes due to lack of direction regarding her preferred language. Findings include:</p> <p>Resident #1 was admitted to the facility on 5/4/18 with multiple diagnoses, including a pelvic fracture, generalized muscle weakness, acute kidney failure, and major depressive disorder.</p> <p>Resident #1's most recent MDS assessment, dated 8/22/18, documented her preferred language was Spanish and she preferred a spanish interpreter to communicate with health care staff and the physician.</p> <p>Resident #1's Baseline Care Plan and Initial Discharge Plan, dated 5/24/18, did not document her preferred language or identify interventions for communication.</p> <p>On 11/26/18 at 3:40 PM, LPN #1 said Resident #1 spoke only Spanish. LPN #1 confirmed the facility had access to an interpreter twenty-four hours per day, seven day per week, and some of the staff spoke Spanish.</p> <p>On 11/27/18 at 9:03 AM, Resident #1 was observed talking in Spanish with a staff member.</p> <p>On 11/27/18 at 2:26 PM, Resident #1 was</p>	F 655	<p>Affected</p> <p>On or before 1/16/19 Resident #1 will be assessed for her preferred communication method, by the Director of Nursing or designee, and her care plan will be updated with her current preference and interventions for communication. The resident's responsible party and primary physician will be notified of care plan revisions and current status.</p> <p>Potential</p> <p>On or before 1/16/19, the Director of Nursing or designee, will audit current residents to identify those who are primarily non-English speaking. Identified residents will be reviewed to ensure their communications preferences and interventions are addressed on the baseline care plan. Follow up will be completed as indicated.</p> <p>Systemic</p> <p>On or before 1/16/19, the Director of Nursing or designee new residents, who are primarily non-English speaking, will be reviewed on admission to ensure their communication preferences and interventions are addressed on their baseline care plan. Follow up will be completed as indicated.</p> <p>On or before 1/16/19, The Staff Development Coordinator or designee,</p>		

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F 655	Continued From page 18 interviewed with the assistance of NA Student #1 interpreting Spanish. Resident #1 said only one staff member spoke Spanish, and the other staff did not use the interpreter service. On 11/30/18 at 4:20 PM, the UCC reviewed Resident #1's Baseline Care Plan. She said Resident #1's preferred language was not included in the Baseline Care Plan but it should have been.	F 655	will educate nursing staff regarding the facilities policy for baseline care plan requirements including the requirement to include non-English speaking needs & resident's preference for communication. QAPI / Monitoring Beginning the week of 1/16/19 An Audit of 5 Residents with Baseline Care Plans will be completed by the Director of Nursing or designee to ensure that residents who are primarily non-English speaking have their communication preferences and interventions addressed on the baseline care plan and reflects the current resident status. Audits will be completed weekly X 4 then Monthly X 2. Results will be reported to the QAPI Committee meeting monthly for 3 months for review and remedial interventions. The Director of Nursing is responsible for monitoring and compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		1/16/19	

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F 657	<p>Continued From page 19</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 observation, resident and staff interview, and record review, it was determined the facility failed to ensure the care plan was revised to reflect a resident's current status and needs. This was true for 1 of 24 residents (Resident #1) whose care plans were reviewed. The failure to revise Resident #1's care plan when her dialysis access device site changed created the potential for harm if her care was not provided and/or decisions were made based on inaccurate information. Findings include:</p> <p>Resident #1 was admitted to the facility on 5/4/18, with multiple diagnoses including acute kidney failure.</p> <p>On 11/27/18 at 2:55 PM, Resident #1 said she</p>	F 657	<p>On 11/29/2018, the care plan for resident # 1 was revised by the Director of Nursing, to reflect her current Dialysis access device site and dialysis needs.</p> <p>Potential</p> <p>On or before 1/16/19, the Director of Nursing or designee, will complete an audit of current residents who require Dialysis. Identified residents will be reviewed to ensure their care plan is reflective of their current Dialysis needs and dialysis access site. Follow up will be completed as indicated.</p> <p>Systemic</p>		

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F 657	<p>Continued From page 20</p> <p>had just returned from dialysis. She showed the surveyor her dialysis access device in her right upper arm, and where she had a previous access device on her left upper chest. A clean, dry, and intact dressing was on the right arm access site. Resident #1 said the facility staff did not check her access device after dialysis and she was the one who removed the dressing 4 hours after dialysis.</p> <p>Resident #1's care plan, dated 8/22/18, included approaches regarding dialysis/renal failure. Interventions on the care plan included:</p> <ul style="list-style-type: none"> * Check the left subclavian (chest wall) dialysis access device site for signs and symptoms of infection, pain, or bleeding, daily and as needed. * Remove the dialysis access device site dressing 4 hours after return from dialysis. * No bandaids on fistula (right upper arm). <p>Resident #1's record included vascular surgeon office visit note. The notes documented the following:</p> <ul style="list-style-type: none"> * 9/10/18 - "...She is status post creation of a right upper arm primary AV [arterial/venous] fistula. She is currently dialyzing through a left IJ [internal jugular] tunneled dialysis catheter...Her right upper arm access has not been struck yet...On physical exam, her access is a nice thrill...I looked at her fistula with duplex scan...and [it] should be ready to access...contact dialysis and told him to start using her fistula..." * 10/24/18 - "...her dual-lumen tunneled hemodialysis catheter...was removed in its entirety..." 	F 657	<p>On or before 1/16/19, licensed nurses will receive education, by the Staff Development Coordinator, regarding the facility process for timely & accurate care plan revisions, including the need to reflect the resident's current status.</p> <p>On or before 1/16/19, residents on Dialysis will be reviewed, by the Director of Nursing or designee, in the morning clinical meeting for changes pertaining to resident's Dialysis needs. Updates will be made to the residents care plan as indicated.</p> <p>QAPI / Monitoring</p> <p>Beginning the week of 1/21/18 An Audit of 5 Residents requiring Dialysis will be completed by the Director of Nursing or designee to ensure that resident's care plan is reflective of the resident's current Dialysis needs, including Dialysis access site.</p> <p>Audits will be completed weekly X 4 then Monthly X 2. Results will be reported to the QAPI Committee meeting monthly for 3 months for review and remedial interventions. The Director of Nursing is responsible for monitoring and compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.</p>		

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F 657	Continued From page 21	F 657			
F 679 SS=D	<p>On 11/30/18 at 11:15 AM, the DON said Resident #1's left subclavian dialysis access device was removed and the dialysis access device was now in her right upper arm. She said the care plan was not updated to include the new dialysis access device and the removal of the old device.</p> <p>Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)</p> <p>§483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and record review, it was determined the facility failed to ensure activities met the interests and supported the physical, mental, and psychosocial well-being of each resident. This was true for 1 of 24 residents (Resident #1) who were reviewed for activities. This failure created the potential for residents to become bored or depressed when she was not provided with meaningful engagement throughout the day. Findings include: Resident #1 was admitted to the facility on 5/4/18, with multiple diagnoses including a pelvic fracture, generalized muscle weakness, acute</p>	F 679	<p>The facility will ensure activities meet the interest and support the physical, mental, and psychosocial well-being of each resident .</p> <p>Resident #1 Activity Plan was reviewed with the resident by the Activity Director. AD ordered the Activity Connection on line . Invoice #205099. This connection includes daily chronicles , word games, etc. in Spanish . Daily Activities calendar will continued to be translated into Spanish by the AD team . Invoice 205099 The mobile library will also provide</p>	1/16/19	

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F 679	<p>Continued From page 22 kidney failure, and major depressive disorder.</p> <p>Resident #1's quarterly MDS assessment, dated 8/22/18, documented her preferred language was Spanish and she needed or wanted an interpreter to communicate with health care staff. Her hearing and vision were adequate and her speech was clear. Her cognition was modified independent (some difficulty in new situations only). It was very important to her to listen to music that she liked, be around animals, do favorite activities, and participate in religious services or practices. It was somewhat important to have things to read, keep up with the news, and do things with groups of people.</p> <p>Resident #1's comprehensive care plan included the following problems and interventions:</p> <p>* Communication barrier related to her speaking Spanish with a minimal understanding of English, dated 8/22/18. Staff were directed to use alternative communication tools, family contact and some staff as translators, a picture recognition book, "Gestures," watching Spanish speaking channels on television, and speaking with other Spanish speaking residents.</p> <p>* Alteration in her mood related to depression, dated 5/24/18. Staff were directed to use a translator, encourage interest in favorite past times and interactions with peers.</p> <p>Resident #1's care plan documented on 6/3/18, she enjoyed doing her favorite activities, which included crafts and fingernail care/polish, are very important to her. The activities staff were directed to translate the morning activity paper</p>	F 679	<p>Spanish reading material for Resident #1.</p> <p>AD will review the residents who do not speak English and will evaluate whether their activities plans meet the interest of the residents.</p> <p>AD will meet weekly with Resident #1 to ensure the resident's interest are being met .</p> <p>ED/designee will visit with the non English speaking residents to ensure their interest are being met.</p> <p>The interviews and review of the activity logs will be completed weekly x 4 then monthly x 2 . Results will be reported to the QAPI committee monthly for 3 months for review and remedial interventions. The ED/designee is responsible for monitoring and compliance . The QAPI Committee will re-evaluate the need for further monitoring after 3 months.</p>		

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F 679	<p>Continued From page 23 and use Google translate during activities.</p> <p>Resident #1's Activities Evaluation, dated 6/11/18, documented current events/news was very important to her, as were family/friend visits, knitting/crocheting, and music. It was documented she wanted staff to take her to fingernail care/polish and craft activities, and she loved cooking and crocheting.</p> <p>On 11/26/18 at 3:35 PM, Resident #1 was in her room sitting in her wheelchair looking toward the window. No lights were on in her room. When the surveyor knocked at her door, she smiled and waved the surveyor into her room. She said she did not speak English in Spanish and nodded her head up and down when the surveyor spoke in English.</p> <p>On 11/27/18 at 2:26 PM, Resident #1 was in her wheelchair in her room. She was wearing her coat. NA Student #1 assisted with interpreting, and Resident #1 said she just returned from dialysis. She said she did go to some activities but she did not participate because she did not understand or know how to do the activity. She said she would like to do more activities but many of the staff only spoke English and she did not understand them.</p> <p>On 11/28/18 at 11:32 AM, the Activities Director (AD) said all residents were given a printed list of the activities for that day, and her assistant translated the daily activities lists to Spanish for Resident #1. The AD accompanied the surveyor to Resident #1's room and pointed out the translated activity list for Wednesday, 11/28/18. The AD said the facility previously used an online</p>	F 679			

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F 679	<p>Continued From page 24</p> <p>program called Activities Connection and Resident #1 really enjoyed reading the daily chronicles in Spanish. The AD said the Activities Connection subscription had expired recently and she was waiting for approval to renew the subscription. The AD said all activities were conducted in English and she and her assistant previously used Google translator on their cell phones to translate for Resident #1 at the beginning of an activity. The AD stated it was difficult to translate and conduct the activity at the same time.</p> <p>On 11/28/18 5:30 PM, the AD provided Resident #1's Individual Resident Daily Participation records for September, October, and November 2018 which documented the following:</p> <p>* September 2018:</p> <ul style="list-style-type: none"> - She actively participated in a beauty/barber activity three times (9/5/18, 9/12/18, and 9/19/18). - She listened to the radio, watched television, and read her Bible daily from 9/1/18 to 9/28/18. - She actively participated in a social activity/party three times (9/19/18, 9/20/18, and 9/28/8). - She actively participated when a family/friend visited twice (9/13/18 & 9/21/18). <p>There was no documentation Resident #1 participated in activities with animals/pets, arts/crafts, current events/news, or knit/crochet.</p> <p>* October 2018:</p> <ul style="list-style-type: none"> - She actively participated in a beauty/barber activity once (10/11/18). - She actively participated in a social 	F 679			

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F 679	<p>Continued From page 25 activity/party once (10/29/18). - She read her Bible daily from 10/1/18 to 10/6/18 and 10/10/18 to 10/14/18, and on 10/23/18 and 10/24/18. - She watched television five times (10/2/18, 10/5/18, 10/6/18, 10/16/18 and 10/26/180.</p> <p>There was no documentation Resident #1 participated in activities with animals/pets, arts/crafts, current events/news, or knit/crochet.</p> <p>* November 2018: - She actively participated in a beauty/barber activity once (11/7/18). - She actively participated when a family/friend visited three times (11/7/18, 11/21/18, and 11/22/18). - She activity participated in a music activity once (11/23/18). - She did not read her Bible, listen to the radio, or watch television. - She activity participated when a staff member made daily visits 5 times (11/9/18, 11/13/18, 11/16/18, 11/19/18, and 11/23/18).</p> <p>There was no documentation Resident #1 participated in activities with animals/pets, arts/crafts, current events/news, or knit/crochet.</p> <p>On 11/29/18 at 11:30 AM, the AD said there was one other Spanish speaking resident in the facility but that resident did not come out of his room very much. She said the facility did not have a policy regarding activities for residents with a communication barrier. She said she checked to see if the facility had a policy regarding cell phone use. She said the facility did have a cell phone use policy and cell phone use</p>	F 679			

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F 679	Continued From page 26 for resident needs was approved.	F 679			
F 684 SS=D	<p>Quality of Care CFR(s): 483.25</p> <p>§ 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, policy review, observation, resident interview, and staff interview, it was determined the facility failed to ensure professional standards of practice were followed for 5 of 25 residents (#39, #46, #50, #258, and #260) who were reviewed for standards of practice. This failure created the potential to adversely affect or harm residents whose care and services were not delivered according to accepted standards of clinical practices. Findings include:</p> <p>1. The Nursing 2018 Drug Book included specific recommendations for crushing medications. One recommendation stated crushing certain oral medications may alter the drug's effect causing overdose or other adverse reactions. Before crushing a medication, always check with the pharmacist and established references.</p> <p>The facility's Oral Medication Administration policy, dated 11/2017, documented staff will check for specific prescriber orders to crush</p>	F 684	<p>Resident # 39 was reviewed by the director of Nursing or designee, on 11/27/18 for crushed medications administration. Resident was reviewed with the physician and an order to crush resident medications was obtained. An ST evaluation was completed on 11/28/18, by the Speech Therapist and orders were received to continue to crush medications and administer in applesauce. The resident care plan was updated to reflect her current status.</p> <p>On 11-29-18 resident # 46 was assisted by the Director of Nursing, to don tubi-grips to bilateral lower extremities and was assessed and found to have no adverse effects related to not wearing the tubi-grips. The physician was notified. On or before 1/16/19, Resident # 46's careplan will be reviewed by the Director of Nursing or designee to ensure the use of Tubi-grips is included and accurately</p>	1/16/19	

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F 684	<p>Continued From page 27</p> <p>medications. Crush medications, if indicated, for a resident only after referring to the Medications Not To Be Crushed List. For products that appear on the Medications Not To Be Crushed List, check with the pharmacist regarding a suitable alternative and request a new prescriber order if appropriate.</p> <p>Resident #39 was admitted to the facility on 10/16/18, with multiple diagnoses including dysphagia (difficulty swallowing), right side hemiplegia and hemiparesis (paralysis and weakness) related to cerebral infarction (stroke), and generalized muscle weakness.</p> <p>Resident #39's admission MDS assessment, dated 10/29/18, documented her cognition was intact and family or significant other participated in the assessment. The MDS assessment documented Resident #39's nutrition required a mechanically altered diet.</p> <p>On 11/27/18 at 8:50 AM, LPN #7 was observed administering medication to Resident #39 that was not crushed. The medications included Eliquis 5 mg, Prozac (antidepressant) 10 mg, calcium carbonate 200 mg/500 mg, docusate sodium (stool softener) 100 mg, and amlodipine (blood pressure medication) 10 mg. All medications were given with water and Resident #39 was observed having difficulty swallowing the medication.</p> <p>On 11/27/18 at 4:38 PM, LPN #6 was observed administering medication to Resident #39 that was crushed. The medications included calcium carbonate 200 mg/500 mg and docusate sodium 100 mg. LPN #6 observed Resident #39 had</p>	F 684	<p>reflects the resident's current status.</p> <p>On 11/26/18, Resident # 258 was assessed by the Resident Care Manager, for respiratory distress with negative findings, and the resident's physician and Responsible party were notified. The order for oxygen was reviewed and the bedside Oxygen liter flow was adjusted to 4LPM per physicians order. The care plan was reviewed for accuracy and updated as indicated.</p> <p>Resident # 50 Discharged from the facility on 12/6/18.</p> <p>Resident # 260 Discharged from the facility on 12/5/18.</p> <p>Potential</p> <p>On 11/27/18, an audit of current residents was completed by the Director of Nursing, to identify residents who require their medications to be crushed. Identified residents were reviewed with the physician and orders were obtained to crush the resident's medications. Care plans for respective residents were updated reflect their current status.</p> <p>On or before 1/16/19 an audit of current residents will be completed by the Director of Nursing or designee, to identify residents requiring oxygen. Identified residents will be reviewed at bedside to ensure current oxygen liter</p>		

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F 684	<p>Continued From page 28</p> <p>regular water at the bedside and stated to Resident #39 even though she was reevaluated by the SLP to start regular water, she should have nectar thick water until there was an order submitted by the SLP. LPN #6 then removed the water and replaced it with nectar thick water. LPN #6 stated she was not sure why LPN #7 did not crush the medications in the morning. LPN #6 stated LPN #7 should have known to crush Resident #39's medications before administering them. LPN #6 stated she was crushing Resident #39's medications for awhile and knew to administer crushed medications during nursing shift report. LPN #6 stated she thought there was a documented order or record that designated medications to be crushed. LPN #6 provided the MAR and physician orders from Resident #39's record, there was no documentation directing staff to crush medications and provide nectar thick water.</p> <p>On 11/28/18 at 10:00 AM, LPN #3 stated he gave uncrushed medication to Resident #39 on that day and the last time, about 4 days ago, he gave her crushed medications. LPN #3 stated pill packs, provided by the pharmacy did not document which medications should be crushed.</p> <p>On 11/28/18 at 10:10 AM, the DON stated she did not know why there was not an order for crushed medications for Resident #39. The DON stated the process for new orders was to document in the resident's record and MAR, then the resident's electronic record was updated as time permitted, and it could take up to a month. The DON stated when residents had issues with dysphagia, nursing staff should notify the physician or the SLP.</p>	F 684	<p>flow is consistent with the physician's orders.</p> <p>Follow up will be completed as indicated and resident care plans will be updated to reflect the resident's current status.</p> <p>On or before 1/16/19 an audit of current residents requiring application of Tubi-grips/ Compression stockings will be completed by the Director of Nursing or designee, to ensure that residents with orders for Tubi-grips / Compression stockings are wearing them according to the physician's order. Identified residents will receive follow up as indicated.</p> <p>On or before 1/16/19, an audit of current diabetic residents will be completed by the Director of Nursing or designee, to identify residents whose hypoglycemic parameters were not followed. Identified residents will be assessed for adverse effects. Current hypoglycemic parameters will be reviewed with the MD for needed revisions and follow up will be completed as indicated.</p> <p>Systemic On or before 1/16/19 the facility staff will receive education, from the Staff Development Coordinator or designee, regarding the facilities policies for crushed medication administration, updated diabetic protocol, application of Tubi-grips. Compression stockings, and Oxygen Administration.</p>		

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F 684	<p>Continued From page 29</p> <p>On 11/28/18 at 1:30 PM, the DON stated staff were to crush medications by direction of a physician's order and it would be documented on the MAR.</p> <p>On 11/28/18 at 2:41 PM, Resident #39 stated she usually received her medications crushed, and there was only one medication she took as a whole pill.</p> <p>On 11/30/18 at 9:00 AM, the SLP stated based on her understanding Resident #39 was taking crushed medications for at least two weeks and probably longer than that. The SLP stated during an assessment she evaluated a resident's ability to swallow by initiating a number of test trials with items such as candy pieces. The SLP stated she evaluated Resident #39 and determined she was able to swallow some pills but not all pills, the bigger pills were more difficult for her to swallow. The SLP stated the DOR and UCC instructed her to not recommend or order medications to be crushed unless she could recommend all medications could be crushed. The SLP made the recommendation to have some of Resident #39's medications crushed, and they told her she could not do that because it was either "all or none."</p> <p>At 11/30/18 at 11:45 AM, the Administrator stated she expected there was a physician's order to crush medications. The Administrator stated she did not know what the facility's policy for crushing medications was, and she was not sure if the order could be submitted by the SLP or by nursing staff.</p>	F 684	<p>On or before 1/16/19 the Director of Nursing or designee, will review new residents requiring crushed medications, in the morning clinical meeting, to ensure a physician's order is in place and the careplan is reflective of current resident's medication administration needs. Follow up will be completed as indicated.</p> <p>On or before 1/16/19 the Director of Nursing or designee will review residents with new or changed orders for oxygen administration, in the morning clinical meeting, to ensure the oxygen liter flow is being delivered at bedside, in accordance with the physicians order for oxygen LPM. Follow up will be completed as indicated.</p> <p>On or before 1/16/19 the Director of Nursing or designee, will review diabetic residents in the morning clinical meeting to ensure blood glucose parameters are followed and interventions are implemented according to the physician's orders. Follow up will be completed as indicated.</p> <p>On or before 1/16/19, the Director of Nursing or designee, will review residents during the morning clinical meeting, to ensure tubi-grips / compression stockings are being applied to residents according to the physician's orders. Follow up will be completed as indicated.</p> <p>On 12/18/18 the facilities current Diabetic</p>		

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F 684	<p>Continued From page 30</p> <p>2. Resident #46 was admitted to the facility on 5/3/18, with diagnoses including atherosclerotic heart disease, atrial fibrillation (irregular heart rhythm), muscle weakness, and wounds to BLE.</p> <p>Review of Resident #46's quarterly MDS assessment, dated 11/10/18, documented he was cognitively intact.</p> <p>A physician order, dated 9/28/18, documented Resident #46 was to have tubigrip stockings (compression stockings to reduce edema in the lower extremities) twice daily, on in morning and off at bedtime for edema.</p> <p>Resident #46's record included a Progress Note, dated 11/2/18, which documented the RN noted 3+ pitting edema to his bilateral feet/ankles. The RN documented Resident #46 was educated about the importance of elevating his BLE, as well as compliance with the tubigrips. The progress note documented the physician was notified and agreeable with the plan of care. At the bottom of the progress note the physician added a hand-written statement which documented "OK. Make sure compliant with compression stockings."</p> <p>Resident #46's November 2018 TAR documented he was to wear compression stockings to both legs daily. The TAR documented the facility did not apply the compression stockings as ordered by the physician on 11/15/18, 11/16/18, 11/18/18, 11/23/18, 11/27/18, and 11/28/18.</p> <p>On 11/28/18 at 10:55 AM, Resident #46 stated a CNA had removed the stockings and told him</p>	F 684	<p>Protocol was reviewed by the Director of Nursing and Medical Director . The Diabetic protocol was updated to current standards.</p> <p>QAPI/Monitoring</p> <p>Beginning the week of 1/16/19 an audit of 5 residents requiring crushed medications, will be completed by the Director of Nursing or designee, to ensure medications are administered according to the physicians order and that the care plan is reflective of current resident's medication administration needs.</p> <p>Beginning the week of 1/16/19 a bedside observation of 5 residents requiring application of Tubi-grips / Compression stockings will be completed by the Director of Nursing or designee, to ensure that residents with orders for Tubi-grips /Compression stockings are wearing them according to the physicians order.</p> <p>Beginning the week of 1/16/19 a bedside observation of 5 residents requiring oxygen, will be completed by the Director of Nursing or designee, to ensure that residents delivery rate of oxygen is consistent with the physicians order.</p> <p>Beginning the week of 1/16/19 an audit of 5 diabetic residents will be completed by the Director of Nursing or designee, to ensure that hypoglycemic interventions are implemented according to physician's orders / parameters and that follow up notifications are made to the</p>		

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F 684	<p>Continued From page 31</p> <p>"they [stockings] were too nasty to wash." Resident #46 stated the CNA had not replaced the stockings, and there were several occasions where the staff failed to apply the compression stockings. At the time of the interview, Resident #46 was not wearing the compression stockings and he stated, "I have edema and need them on."</p> <p>On 11/29/18 at 9:50 AM, LPN #2 stated it was the responsibility of the CNAs to apply the stockings.</p> <p>On 11/29/18 at 10:00 AM, CNA #1 stated it was the nurse's responsibility to apply the compression stockings because it was a treatment.</p> <p>On 11/29/18 at 10:25 AM, the DON stated the compression stockings could be applied by either the CNAs or the LPNs. The DON stated the CNAs should notify the LPN if the resident refused or if there was a problem, and the LPN should document the conversation. The DON stated if the CNA failed to apply the stockings it fell to the LPNs to ensure the orders were followed. The DON reviewed the November TAR for Resident #46 and confirmed it was blank with no documentation to indicate the compression hose were applied as ordered for the above listed dates.</p> <p>3. The Centers for Disease Control and Prevention (CDC) website, updated on 8/15/18, and accessed on 12/3/18, included specific recommendations for hypoglycemia. One recommendation was keeping blood glucose levels as close to target as possible to help prevent complications. The CDC also stated</p>	F 684	<p>physician as indicated.</p> <p>Audits will be completed weekly X 4 then Monthly X 2. Results will be reported to the QAPI Committee meeting monthly for 3months for review and remedial interventions.</p> <p>The Director of Nursing is responsible for monitoring and compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.</p>		

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F 684	<p>Continued From page 32</p> <p>regular blood glucose monitoring was the most important intervention to manage diabetes. The CDC website stated with low blood glucose levels the brain does not get enough glucose and stops functioning as it should.</p> <p>The facility's Hypoglycemic Reaction policy, dated 10/2014, included directions and guidelines for the care of the resident experiencing a hypoglycemic reaction. The policy stated the nurse must use good clinical judgment in the treatment of the resident based on the blood glucose value, resident specific parameters of blood glucose ranges, and the consciousness of the resident. The policy further stated staff will document in the record the signs and symptoms, assessment, blood glucose values, attempts to give oral carbohydrates, glucagon injection location, the resident's response, and notification of physician and family.</p> <p>Resident #50 was admitted to the facility on 11/7/18, with multiple diagnoses including Type 2 diabetes mellitus with other diabetic kidney complications, long term use of insulin, and hypertension.</p> <p>Resident #50's admission MDS assessment, dated 11/14/18, documented his cognition was moderately impaired, and family or significant other participated in the assessment. The MDS assessment documented Resident #50 received insulin medication on a routine basis.</p> <p>Resident #50's physician orders, dated 11/7/18, documented he was prescribed Humalog (insulin) and sliding scale insulin. The American Diabetes Association defines sliding scale as a</p>	F 684			

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F 684	<p>Continued From page 33</p> <p>set of instructions for adjusting insulin on the basis of blood glucose test results, meals, or activity levels.</p> <p>Resident #50's care plan, dated 11/8/18, identified his Type 2 diabetes mellitus and the order for Humalog insulin and sliding scale therapy. The care plan identified hypoglycemic goals and directed staff to perform blood sugar checks and monitor signs and symptoms of hypoglycemia.</p> <p>Resident #50's MAR documented on 11/15/18, he had a blood sugar value of 65, and on 11/21/18, he had a blood sugar value of 60.</p> <p>Resident #50's November 2018 Blood Glucose Protocol record did not document an intervention on 11/15/18 or 11/21/18. The Blood Glucose Protocol documented the following:</p> <ul style="list-style-type: none"> - Notify physician for blood sugars less than 60 or greater than 400 unless specified by sliding scale. Follow facility clinical protocol. - If the resident's blood sugar is less than 80, resident is awake with an intact gag reflex, and can swallow, give 15-20 grams of fast acting glucose. (Ex: 120 cc juice, glucose gel, 4 tsp sugar mixed in liquid.) Repeat blood sugar in 15 minutes. If blood sugar less than 80 repeat 15-20 grams of fast acting glucose. Repeat blood sugar in 15 minutes. Repeat above steps until resident is stable and blood sugar is at or above 80. Follow up with meal or significant snack. (document amount consumed) 	F 684			

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F 684	<p>Continued From page 34</p> <p>Recheck blood sugar in 15 minutes. If not responding to treatment give glucagon and call MD.</p> <p>- If the resident is unconscious or cannot ingest sugar treatment: Give glucagon 1 mg subcutaneous (into soft tissue) or intramuscular (into the muscle). Recheck blood glucose in 15 minutes or sooner if condition worsening. If resident is responding: give 15-20 gram of fast acting glucose, (ex: 120 cc juice, glucose gel or 4 tsp sugar). Recheck blood sugar in 15 minutes, if blood sugar is greater than 80 follow up with a meal or significant snack (document amount consumed). If resident fails to respond, call Emergency Services, physician and family.</p> <p>On 11/29/18 at 11:25 AM, LPN #4, with the RDCS present, stated he followed the hypoglycemic protocol and verbalized the entire protocol description from the MAR. After reviewing Resident #50's record, LPN #4 confirmed he had a low blood glucose on 11/15/18 and 11/21/18, and he sometimes had a low blood sugar at night. LPN #4 then reviewed the sliding scale numbers and parameters for Resident #50, which documented for a blood sugar less than 149, hold the insulin. LPN #4 stated the sliding scale indicated a value at which insulin should not be given and no other interventions. LPN #4 stated he would not follow the hypoglycemic protocol on the MAR, and that was the reason why there was not an intervention on the hyperglycemic protocol sheet and a recheck blood sugar was not done.</p>	F 684			

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F 684	<p>Continued From page 35</p> <p>On 11/29/18 at 12:45 PM, the DON, with the UCC and RDCS present, stated the hypoglycemic protocol should be individualized for each resident. The DON stated Resident #50 should have had an intervention and blood sugar check after 15 minutes and documented on the protocol sheet. The DON stated the sliding scale should not be used as the number for intervention of blood sugars less than 60 or 80.</p> <p>4. The American Association for Respiratory Care (AARC) website, updated on 10/24/16, and accessed on 12/3/18, stated the body needs oxygen to keep the blood adequately saturated in order for cells and tissues to get enough oxygen to function properly. The website included the recommendation for supplemental oxygen when the oxygen saturation falls below 89 percent, or when the arterial oxygen pressure falls below 60 mmHg (millimeters of mercury).</p> <p>The facility's Oxygen Therapy policy, dated 2/20/15, directed staff to ensure all patients who require supplementary oxygen receive therapy that is appropriate to their clinical condition.</p> <p>a. Resident #258 was admitted to the facility on 11/21/18, with multiple diagnoses including pneumonia due to haemophilus influenzae (bacterium that can cause a severe infection), acute and chronic respiratory failure with hypoxia (lack of oxygen), insomnia, other lung disorders, and dysphagia (difficulty swallowing).</p> <p>Resident #258's admission MDS assessment, dated 11/29/18, documented she received oxygen therapy.</p>	F 684			

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F 684	<p>Continued From page 36</p> <p>Resident #258's physician orders, dated 11/21/18, documented she was prescribed an oxygen flow rate of 4 liters via nasal cannula or by mask to keep oxygen saturation greater than or equal to 90% and to check oxygen saturation levels as needed for shortness of breath.</p> <p>On 11/26/18 at 4:24 PM, Resident #258's cognition was observed to be intact. She was sitting in her recliner and received an oxygen flow rate of 3 liters via nasal cannula. Resident #258 stated she should have been receiving 4 liters of oxygen via nasal cannula.</p> <p>On 11/26/18 at 6:00 PM, the UCC stated checked Resident #258's oxygen setting from the wall concentrator and stated the oxygen flow rate was set at 3 liters via nasal cannula. The UCC then reviewed the physician's orders for Resident #258 and stated the oxygen flow rate should have been set at 4 liters via nasal cannula. The UCC then changed the settings to an oxygen flow rate of 4 liters.</p> <p>b. Resident #260 was admitted to the facility on 11/22/18, with multiple diagnoses including obstructive sleep apnea, chronic obstructive pulmonary disease, and muscle weakness.</p> <p>Resident #260's physician orders, dated 11/19/18, documented she was prescribed continuous oxygen at 2 liters via nasal cannula.</p> <p>Resident #260's November 2018 MAR documented she was to receive 2 liters of oxygen via nasal cannula to maintain an oxygen saturation greater than or equal to 92% and document every shift.</p>	F 684			

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F 684	Continued From page 37 On 11/26/18 at 4:51 PM, Resident #260's cognition was observed to be intact. She was lying in bed and had an oxygen flow rate of 1 liter via nasal cannula. The humidifier was not bubbling. Resident #260 stated she should have been receiving 2 liters of oxygen via nasal cannula. On 11/26/18 at 6:15 PM, the UCC checked Resident #260's oxygen setting on the wall concentrator and stated the oxygen flow rate was set on 1 liter via nasal cannula. The UCC then reviewed the physician's orders for Resident #260 and stated the oxygen flow rate should have been set at 2 liters via nasal cannula. The UCC then changed the settings to an oxygen flow rate of 2 liters.	F 684			
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it	F 686		1/16/19	Affected

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F 686	<p>Continued From page 38</p> <p>was determined the facility failed to coordinate care to prevent the development of an avoidable pressure ulcer. This was true for 1 of 2 residents (Resident #29) who were reviewed for pressure ulcers. Staff failed to follow physician orders to remove a leg brace and to conduct skin assessments. This resulted in harm for Resident #29 when they developed a pressure ulcer which required skin grafting and a lengthy healing period. Findings include:</p> <p>Resident #29 was admitted to the facility on 7/4/18, with diagnoses which included a right femur (thighbone) fracture.</p> <p>Resident #29's hospital discharge summary, dated 7/4/18, documented "Upon arrival at new facility: Encourage up in Chair every 4-6 hrs [hours] or 3 times daily. Non-weight bearing right lower extremity. Work on bed to chair transfers. Remove brace for physical therapy."</p> <p>Resident #29's July 2018 MAR documented "FYI: NWB (non-weight bearing) RLE [right lower extremity]. Encourage up in chair every 4-6 hours or 3 times daily. Work on bed to chair transfers; remove brace for physical therapy." The MAR did not include documentation licensed nursing staff acknowledged the order and it was followed.</p> <p>Review of Resident #29's TAR, dated 7/4/18 through 7/20/18, did not include documentation her skin was monitored around and under the RLE brace.</p> <p>Resident #29's Physical Therapy Evaluation and Plan of Treatment, dated 7/5/18 through 7/26/18, identified the following</p>	F 686	<p>On 1/2/18, Resident # 29 was assessed by the Director of Nursing or designee, and found not to have a brace in place. Therapy, RP and the resident's physician were updated of the resident's current status and the care plan reviewed for accuracy/current resident status and follow up for identified issues was completed as indicated.</p> <p>Potential</p> <p>On or before 1/16/19, the Director of Nursing or designee, will complete an audit of current residents to identify those with medical devices. Identified residents will be reviewed to ensure that physician's orders are in place, for either removable or non-removable devices with skin checks as indicated. The therapy department will be notified of resident's current orders for medical device use and care plans will be updated for respective residents as indicated.</p> <p>Systemic</p> <p>On or before 1/16/19, the Director of Nursing or designee will review residents with new orders for either removable / non-removable medical devices to ensure orders for monitoring of skin and/or surrounding tissue have been implemented. The therapy department will be notified of the resident's order for</p>		

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F 686	<p>Continued From page 39</p> <p>precautions/contraindications: non-weight bearing of the right lower extremity, fall risk, and knee immobilizer on at all times.</p> <p>A telephone order, dated 7/19/18 at 1:00 PM, documented Resident #29 had a consultation with a wound care nurse for right lateral (outer) ankle decubitus ulcer. The order included discontinuing the knee immobilizer.</p> <p>A Nursing Progress Note, dated 7/20/18, documented Resident #29 was seen at the orthopedic physician's office and a 7 cm (centimeter) by 4 cm unstageable wound (unable to see the bed of the wound), was identified on the posterior calf related to the leg brace.</p> <p>Resident #29's Treatment Record, dated 7/20/18, documented wound care orders were initiated.</p> <p>Resident #29's Wound Clinic Physician Progress Note, dated 7/31/18, documented "Patient in today for the assessment of an unstageable pressure injury to the right lower lateral leg. The wound bed was 100% non-viable tissue. Debridement [removal of unhealthy tissue] is needed, but the tissue was too adherent for sharps debridement today." The wound measured 4.0 cm x 3.5 cm x 0.1 cm.</p> <p>Resident #29's Nursing Progress Note, dated 9/4/18, documented "Resident continues with mechanical injury to right posterior calf from a brace that continues to be unstageable, wound bed measures 5.5 cm x 3 cm x <0.5 cm. White tendon present in middle of wound bed. Slight</p>	F 686	<p>medical device use. The care plan will be updated to reflect the resident's current status, and follow up completed as indicated.</p> <p>On or before 1/16/19, therapy and licensed nurses will receive education from the Staff Development Coordinator or designee, regarding the facility policy for skin care with use of medical devices, as well as communication expectations, for residents with medical device use, to the therapy department.</p> <p>QAPI / Monitoring</p> <p>Beginning the week of 1/16/19, an audit of residents requiring the use of medical devices, will be conducted by the Director of Nursing or designee, to ensure therapy awareness of the plan for medical device use & that skin monitoring is being completed around and/or under the brace as indicated/ordered.</p> <p>Audits will be completed weekly X 4 then Monthly X 2. Results will be reported to the QAPI Committee meeting monthly for 3 months for review and remedial interventions. The Director of Nursing is responsible for monitoring and compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.</p>		

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F 686	<p>Continued From page 40</p> <p>odor noted. Resident is followed by [physician name] for wound orders to RLE. Procedure for right leg debridement and wound vacuum placement are scheduled on 9/20/18."</p> <p>A Nursing Progress Note, dated 9/28/18, documented a wound vacuum to Resident #29's right posterior calf was changed on that day per physician orders. The wound was surgically debrided and measured 5.0 cm x 2.5 cm x 0.5 cm.</p> <p>A hospital operative note, dated 10/18/18, documented Resident #29 had a skin graft (a procedure to remove skin from her right thigh and suture it onto the wound). Tissue that measured 5.0 cm x 5.0 cm was removed from her right thigh and sutured on top of the wound on her RLE.</p> <p>Resident #29's November 2018 Treatment Record documented the wound resolved on 11/20/18.</p> <p>On 11/29/18 at 9:38 AM, the DON said if a resident had a non-removable device the nurse should check the skin around the area of the brace and document on the TAR every shift.</p> <p>On 11/29/18 at 3:18 PM, the Director of Therapy confirmed she did not reference the admission orders for Resident #29, and she only referenced the therapy notes from the hospital. The Director of Therapy said the nurse who noted the therapy orders did not communicate the brace was to be off during therapy and it was not her practice to check physician orders. The Director of Therapy said Resident #29 had a RLE brace and received</p>	F 686			

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F 686	Continued From page 41 therapy 6 days a week from 7/4/18 through 7/19/18, but the therapy department did not remove the brace. On 11/30/18 at 10:08 AM, the DON said the admission nurse failed to communicate to therapy the physician order for removal of Resident #29's brace during physical therapy. Review of the Skin Guidelines, dated 9/11/18, did not address the coordination of care between nursing and therapy for new admissions with devices such as braces and splints. The DON did not provide a facility policy for skin checks under a brace or device. On 11/30/18 at 8:54 AM, LPN #3 stated, "When I took care of the resident the brace was not supposed to come off." LPN #3 said if skin checks were done they would be documented on the weekly skin sheet.	F 686			
F 698 SS=D	Dialysis CFR(s): 483.25(l) §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, resident interview, staff interview, and record review, review of the facility/dialysis provider agreement, and review of facility policy, it was determined the facility failed to ensure physician orders and the care plan related to dialysis care and services were updated and implemented when the access	F 698	On 11/29/2018, the care plan for Resident # 1□s was reviewed & revised by the Director of Nursing, to reflect her current Dialysis access device site and dialysis needs. On or before 1/16/19, Resident # 1 will be	1/16/19	

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F 698	<p>Continued From page 42</p> <p>device site changed, and that pre and post-dialysis assessments were consistently completed for 1 of 1 resident (Resident #1) who was reviewed for dialysis. The failure created the potential for harm if undetected complications went untreated or there was a delay in treatment. Findings include:</p> <p>The facility/dialysis provider agreement, made and entered into on 10/18/07, documented, "...Facility shall ensure that all appropriate medical, social, administrative, and other information accompany all Designated Residents at the time of transfer to Center [dialysis provider]. This information, shall include... Treatment presently being provided to the Designated Resident, including medications and any changes in a patient's condition... Any other information that will facilitate the adequate coordination of care, as reasonably determined by Center...Facility will provide for the interchange of information useful or necessary for the care of the Designated Resident..."</p> <p>The facility's Dialysis policy, revised 11/28/16, documented, "The dialysis patient shall receive consistent care pre and post-dialysis. The shunt site shall be checked on a daily basis..." and, on the Day of Dialysis, facility staff were to complete and send the dialysis form with the resident and after dialysis they were to, "1. Obtain vital signs...2. Follow routine dialysis instructions on dialysis transfer form...5. Monitor shunt site on a routine basis..."</p> <p>Resident #1 was admitted to the facility on 5/4/18, with multiple diagnoses including acute kidney failure.</p>	F 698	<p>assessed, by the Director of Nursing or designee, for adverse effects related to inconsistent completion of the pre / post dialysis assessments. The physician will be notified of resident current status and follow up will be completed as indicated.</p> <p>Potential</p> <p>On or before 1/16/19, The Director of Nursing or designee will complete an audit of current residents who require Dialysis. Identified residents will be reviewed to ensure their care plan is reflective of their current Dialysis needs and dialysis access site. Follow up will be completed as indicated.</p> <p>On or before 1/16/19, the Director of Nursing or designee will complete an audit of current residents who require Dialysis to evaluate for consistent completion of the Pre/Post Dialysis Assessments. Identified residents will have follow up completed as indicated.</p> <p>Systemic</p> <p>On or before 1/16/19, staff will receive education, from the Staff Development Coordinator or designee, regarding the facility process for timely and accurate care plan revisions, including the need for the care plan to reflect the resident's current status.</p> <p>On or before 1/16/19, Licensed Nurses</p>		

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F 698	<p>Continued From page 43</p> <p>Resident #1's dialysis/renal failure care plan, dated 8/22/18, included approaches to:</p> <ul style="list-style-type: none"> * Check her left subclavian dialysis access device site for signs and symptoms of infection, pain, or bleeding daily and as needed * Communicate her care in collaboration with the dialysis center * Remove the dialysis access device site dressing 4 hours after her return from dialysis <p>Resident #1's physician orders, dated 9/25/18, included the following:</p> <ul style="list-style-type: none"> * The left subclavian access site dressing to be changed by the dialysis provider after dialysis on Tuesday, Thursday, and Saturday; * Facility staff to observe the left subclavian access device site every shift for signs and symptoms of infection (redness, swelling, pain, drainage, etcetera) and document "+ if present / - if not present" and notify the dialysis provider if needed. * Lidocaine cream 3% - rub on right arm port site one hour before dialysis 3 times weekly. <p>On 11/27/18 at 9:03 AM, Resident #1 was observed near an exit in her wheelchair wearing a coat and talking with the transportation staff member. The transportation staff member said she was going to take Resident #1 to dialysis.</p> <p>On 11/27/18 at 2:55 PM, Resident #1 said she had just returned from dialysis. She showed the surveyor her dialysis access device in her right upper arm, and where she had a previous access device on her left upper chest. A clean, dry, and</p>	F 698	<p>will receive education from the Staff Development Coordinator or designee, regarding the facility process for Pre/Post Dialysis assessment completion.</p> <p>On or before 1/16/19 the Director of Nursing or designee, will review residents requiring dialysis during the morning clinical meeting, for completion of the pre / post dialysis assessment. Follow up will be completed as indicated.</p> <p>QAPI / Monitoring</p> <p>Beginning the week of 1/16/19, an audit of 5 Residents requiring Dialysis will be completed by the Director of Nursing or designee to ensure that the pre / post Dialysis assessments are completed and that the resident's care plan is reflective of the resident's current Dialysis needs, including Dialysis access site.</p> <p>Audits will be completed weekly X 4 then Monthly X 2. Results will be reported to the QAPI Committee meeting monthly for 3 months for review and remedial interventions. The Director of Nursing is responsible for monitoring and compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.</p>		

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F 698	<p>Continued From page 44</p> <p>intact dressing was on the right arm access site. Resident #1 said the facility staff did not check her access device after dialysis and she was the one who removed the dressing 4 hours after dialysis.</p> <p>Resident #1's clinical record included Pre/Post Dialysis Communication records. These records had 3 sections with instructions for facility staff to complete pre-dialysis and post-dialysis assessments. The dialysis center was to complete the second section. The pre and post-dialysis sections included areas to document vital signs (temperature, blood pressure, pulse, and respirations), weight in pounds with a box to check if she refused to be weighed, the condition of the access/site, whether thrill and bruit (thrill, or vibration, indicates arterial and venous blood flow and patency; bruit, or a "swishing" sound, indicates patency) were present or not, and the signature/title of the person completing each section.</p> <p>Resident #1's Pre/Post Dialysis Communication records for November 2018 documented the following:</p> <ul style="list-style-type: none"> * She was not weighed, and there was no documentation she refused to be weighed, for the pre-dialysis assessments on 11/1/18, 11/3/18, 11/6/18, 11/10/18, 11/15/18, 11/17/18, 11/20/18, 11/22/18, 11/24/18, 11/27/18, and 11/29/18. * Her pulse was not checked on 11/29/18, pre-dialysis. * She was not monitored post-dialysis, this 	F 698			

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F 698	<p>Continued From page 45 section was blank, on 11/1/18, 11/3/18, 11/6/18, 11/13/18, 11/15/18, 11/17/18, 11/20/18, 11/24/18, 11/27/18, and 11/29/18.</p> <p>* She was not weighed and there was no documentation of a refusal for post-dialysis on 11/10/18 and 11/22/18.</p> <p>* The condition of her access site and the thrill and bruit were not assessed post-dialysis and the staff member did not document their signature/title on 11/15/18.</p> <p>* Thrill was not assessed post-dialysis on 11/22/18.</p> <p>Resident #1's vascular surgeon office visit notes documented the following:</p> <p>* 9/10/18 - "...She is status post creation of a right upper arm primary AV [arterial/venous] fistula. She is currently dialyzing through a left IJ [internal jugular] tunneled dialysis catheter...Her right upper arm access has not been struck yet...On physical exam, her access is a nice thrill...I looked at her fistula with duplex scan...and [it] should be ready to access...contact dialysis and told him to start using her fistula..."</p> <p>* 10/24/18 - "...her dual-lumen tunneled hemodialysis catheter...was removed in its entirety..."</p> <p>On 11/29/18 at 4:58 PM, RN #1 said Resident #1 returned to the facility sometime around 2:00 PM but she had not seen her yet. The RN said she removed the dressing off her "left" arm access device between 4 to 6 hours after her return to</p>	F 698			

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F 698	Continued From page 46 the facility and she checked for the bruit at that time. She said nurses removed the dressing, not the resident. Regarding the pre and post dialysis communication form, RN #1 said she had not been completing the post dialysis section because she did not know it needed to be completed. On 11/30/18 at 10:00 AM, the DON reviewed Resident #1's dialysis communication forms and said the nurses were not consistently completing the dialysis communication forms. She said however, the facility's Registered Dietitian (RD) and the dialysis center RD had decided the facility would use the weights obtained at the dialysis center. On 11/30/18 at 11:15 AM, the DON said Resident #1's left subclavian dialysis access device was removed and the access device was in her right upper arm now. She said the care plan and MAR were being updated to reflect the change. The DON said she did not find documentation of communication between the facility RD and the dialysis center RD regarding monitoring Resident #1's weight. She said Resident #1's weight should have been obtained and monitored pre and post-dialysis, but confirmed it was not.	F 698			
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours	F 732		1/16/19	

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F 732	<p>Continued From page 47</p> <p>worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:</p> <p>(A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.</p> <p>§483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.</p> <p>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the posted daily nurse staffing information was complete. This failure created the potential for harm for all residents living in the facility, their family members, and/or visitors if they wanted to know the facility's staffing levels in comparison to the</p>	F 732	<p>The facility will ensure the posted daily nurse staffing information is complete.</p> <p>The staffing coordinator is completing the posted daily nurse staffing information .</p>		

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F 732	Continued From page 48 number of residents in the facility to ensure enough staff were present to meet the needs and cares of those residents. Findings include: On 11/26/18 at 3:06 PM, 11/27/18 at 9:06 AM, and 11/28/18 at 10:35 AM, the resident census was observed to be blank on the facility's posted nurse staffing information. On 11/28/18 at 10:35 AM, the Administrator accompanied the surveyor to the area where the nurse staffing information was posted. The Administrator said the resident census information was blank on the posted nurse staffing information. On 11/28/18 at 11:09 AM, the Administrator and the RDCS were present when the Staffing Coordinator (SC) said she had just added the resident census information to the retained nurse staffing information sheets for 11/1/18 through 11/27/18. The SC also said she had not been putting the resident census information on the posted staffing information sheet.	F 732	All residents living in the facility, their family members and or visitors could be affected by the practice . Staffing Coordinator will complete the staffing information including the census daily. ED/or designee will audit the daily staffing sheets. Audits will be completed weekly x 4 weeks then monthly x 2 . Results will be reported to the QAPI Committee monthly for 3 months for review and remedial interventions . The QAPI Committee will re-evaluate the need for further monitoring after 3 months.		
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	F 761		1/16/19	

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F 761	<p>Continued From page 49</p> <p>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.</p> <p>§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 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 policy review, observation, and staff interview, it was determined the facility failed to ensure expired medications were not available for administration to residents. This was true for 1 resident (#4), 2 of 2 medication storage rooms, and 1 of 4 medication carts reviewed for storage and labeling medication. This failure had the potential for harm should residents receive expired medications with decreased efficacy, potency, and safety. Findings include:</p> <p>The U.S. Food and Drug Administration (FDA) website, updated on 9/6/18, and accessed on 12/3/18, included specific recommendations for expired medication. One recommendation documented the medicine expiration date was a critical part of deciding if the product was safe to use and would work as intended. The expiration date reflects the time period during which the product was expected to remain stable, or retain its identity, strength, quality, and purity, when it was properly stored according to its labeled</p>	F 761	<p>Affected</p> <p>On 11/28/18, Resident # 4's expired lorazepam, was wasted according to the facility policy for destruction of drugs and biologicals.</p> <p>On 11/27/18, Two (2) opened, unlabeled / undated bottles of Vashe, from the Sawtooth medication storage room, were destroyed according to facility policy for destruction of drugs and biologicals.</p> <p>On 11/27/18, 20 containers of Jevity 1.2 CAL was destroyed, according to the facility policy for destruction of drugs and biologicals.</p> <p>On 11/28/18, the partially used bottle of Vashe (from the Shoshone Medication Cart) was destroyed according to the facility policy for destruction of drugs and</p>		

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F 761	<p>Continued From page 50</p> <p>storage conditions. The FDA recommended the safest route to always use medications that are not expired.</p> <p>The facility's Medication Storage policy, dated 11/2017, directed staff to ensure outdated, contaminated, discontinued, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy.</p> <p>On 11/27/18 at 9:00 AM, LPN #7 was observed administering medications to residents, and the medication storage room on the Sawtooth Floor of the facility was reviewed for storage and labeling concerns. Medications were not appropriately labeled and stored, and were expired. Examples include:</p> <ul style="list-style-type: none"> - The medication storage room had 2 opened and partially used Vashe Wound Solution. The containers were not labeled with a resident's name and were placed among other new supplies. LPN #7 acknowledged the Vashe containers were opened and unlabeled, and then threw them away. - 20 containers of Jevity 1.2 CAL were observed in the medication storage room with an expiration date of 10/19/18. LPN #7 acknowledged the expired Jevity 1.2 CAL and stated it would be taken care of by the Central Supply Director (CSD). <p>On 11/27/18 at 9:13 AM, the CSD stated she</p>	F 761	<p>biologicals.</p> <p>Potential</p> <p>On or before 1/16/19, an audit of current medication carts & storage rooms will be completed by the Director of Nursing or designee, to ensure expired & open/unlabeled medications and biologicals, are not available for administration to residents. Medications and biologicals identified to be expired or open / unlabeled, will be disposed of according to facility policy.</p> <p>Systemic</p> <p>On or before 1/16/19, the Central Supply Coordinator and nursing staff will receive education from the Staff Development Coordinator or designee, to review the facilities policy regarding storage and labeling of medications and biologicals.</p> <p>On or before 1/16/19, the Director of Nursing or designee, will complete monthly checks of the drug and biological storage areas including the medication storage rooms, medication carts, central supply storage areas and medication refrigerators. Corrective action will be taken for unlabeled or expired drugs or biologicals.</p> <p>QAPI / Monitoring</p> <p>Beginning the week of 1/16/19, an audit of facility medication carts and medication</p>		

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F 761	Continued From page 51 knew about the expired Jevity but she forgot about it. She was going to throw it out, but let it lapse because she did not have anyone to take care of it. The CSD stated she did not know about the Vashe being opened and it would be taken care of. On 11/28/18 at 1:47 PM, LPN #2 reviewed the medication in the refrigerator of the medication storage room on the Shoshone Falls Floor of the facility. The medication refrigerator contained Lorazepam 2mg/1ml oral for Resident #4 with an expiration date of 9/14/18. LPN #2 acknowledged the expired date and said she would take care of it. On 11/28/18 at 1:47 PM, LPN #2 reviewed the medication cart on the Shoshone Floor of the facility. One opened and partially used Vashe Wound Solution container was in the cart and was not labeled with a resident's name. LPN #2 stated Vashe was used for a single resident but they were no longer using it.	F 761	storage rooms will be completed by the Director of Nursing or designee, to ensure that medications are labeled as indicated and expired medications are not available for administration to residents. Audits will be completed weekly X 4 then Monthly X 2. Results will be reported to the QAPI Committee meeting monthly for 3 months for review and remedial interventions. The Director of Nursing is responsible for monitoring and compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the	F 881	Affected	1/16/19	

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F 881	<p>Continued From page 52</p> <p>facility failed to implement the antibiotic stewardship protocol for 1 of 2 residents (Resident #50) who were reviewed for antibiotic use. This deficient practice created the potential for harm should residents receive ineffective or unnecessary treatment for a suspected urinary tract infection. Findings include:</p> <p>Review of the Antibiotic Stewardship protocol, dated 3/2017, documented nurses are to complete a suspected UTI (Urinary Tract Infection) SBAR (Situation, Background, Assessment, Recommendation) document before contacting the physician for orders.</p> <p>Resident #50 was admitted to the facility on 11/7/18, with multiple diagnoses including benign prostatic hyperplasia with lower urinary tract symptoms.</p> <p>Resident #50's physician orders, dated 11/28/18 at 9:30 AM, documented "Start Ceftin (a medication to fight bacteria) 250 milligrams by mouth BID (twice daily) x 10 days if not already started on something."</p> <p>Review of Resident #50's preliminary urine culture report, dated 11/29/18 at 4:00 PM, identified the presence of yeast.</p> <p>Resident #50's physicians orders, dated 11/29/18 at 4:10 PM, directed staff to discontinue the Ceftin and start Diflucan (an antifungal medication) 100 mg by mouth daily for 14 days.</p> <p>Resident #50's record did not document a UTI SBAR was completed after a UTI was suspected.</p>	F 881	<p>Resident # 50 Discharged from the facility on 12/6/18.</p> <p>Potential</p> <p>On or before 1/19/18, an audit of current residents being treated with antibiotics for urinary tract infections, will be completed by the Director of Nursing or designee. Identified residents will be reviewed to ensure the UTI SBAR was completed and UTI criteria met prior to contacting the physician for initiation of antibiotic treatment. Follow up will be completed for respective residents as indicated.</p> <p>Systemic</p> <p>On or before 1/16/19, licensed staff will be educated, by the Staff Development Coordinator or designee, regarding the facility policy for anti-biotic stewardship including the use of the UTI SBAR for residents with symptoms of a urinary tract infection.</p> <p>On or before 1/16/19 the Staff Development Coordinator or designee will review residents with new urinary tract infection symptoms in the morning clinical meeting, to ensure a UTI SBAR is completed prior to contacting the physician for further orders.</p> <p>QAPI / Monitoring</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2018
NAME OF PROVIDER OR SUPPLIER BRIDGEVIEW ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301		
(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 881	<p>Continued From page 53</p> <p>On 11/30/18 at 12:21 PM, RN #5 stated the best practice was for the physician to get the preliminary culture report back before prescribing an antibiotic. RN #5 stated if a resident had discomfort, then Pyridium (a medication that helps to alleviate urinary tract symptoms) could be prescribed until the report was obtained.</p> <p>On 11/30/18 at 12:33 PM, RN #5 confirmed the antibiotic stewardship protocol was not followed for Resident #50.</p>	F 881	<p>Beginning the week of 1/16/19, the Director of Nursing or designee, will complete an audit of 5 residents being treated with antibiotic medication for Urinary Tract Infections, to ensure a UTI SBAR was completed, according to the facility's antibiotic stewardship policy prior to being treated with an anti-biotic medication.</p> <p>Audits will be completed weekly X 4 then Monthly X 2. Results will be reported to the QAPI Committee meeting monthly for 3 months for review and remedial interventions. The Director of Nursing is responsible for monitoring and compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.</p>		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2018
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NAME OF PROVIDER OR SUPPLIER BRIDGEVIEW ESTATES	STREET ADDRESS, CITY, STATE, ZIP CODE 1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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C 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the unannounced federal recertification and complaint investigation survey of the facility. The survey team entered the facility November 26, 2018 and exited with the facility on December 3, 2018. The surveyors conducting the survey were:</p> <p>Linda Kelly, RN, Team Coordinator Wendi Gonzales, RN Kathryn Davis, RN Geri Wolfe, RN</p>	C 000		
C 762	<p>02.200,02,c,ii When Average Census 60-89 Residents</p> <p>ii. In SNFs with an average occupancy rate of sixty (60) to eighty-nine (89) patients/residents a registered professional nurse shall be on duty for each a.m. shift (approximately 7:00 a.m. - 3:00 p.m.) and p.m. shift (approximately 3:00 p.m. to 11:00 p.m.) and no less than a licensed practical nurse on the night shift.</p> <p>This Rule is not met as evidenced by: Based on review of the Three-Week Nursing Schedule and staff interview, it was determined the facility did not meet the State requirement for RN (Registered Nurse) coverage when the resident occupancy rate was between 60 and 89 residents. Inadequate RN coverage had the potential to negatively affect all residents living in the facility. Findings include:</p> <p>The facility completed and presented a Three-Week Nursing Schedule, dated 11/4/18</p>	C 762	<p>The facility will ensure when the facility census is averaging 60 to 89 patients/residents a registered professional nurse shall be on duty for each a.m. shift.</p> <p>The facility scheduler will schedule a RN on the AM shift for the facility when census is above 60.</p> <p>ED/designee will audit the daily staffing</p>	1/16/19

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

TITLE

(X6) DATE
01/03/19

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2018
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NAME OF PROVIDER OR SUPPLIER BRIDGEVIEW ESTATES	STREET ADDRESS, CITY, STATE, ZIP CODE 1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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C 762	<p>Continued From page 1</p> <p>through 11/24/18, which documented the number of hours worked by all nursing staff, including RNs, on each shift (days, evenings, and nights) for each day during the three week period. The schedule documented an RN was not on duty during the day shift (approximately 7:00 AM to 3:00 PM) for 15 of 15 days (11/7/18 through 11/12/18 and 11/16/18 through 11/24/18) when the resident census was 60 or greater.</p> <p>On 11/30/18 at 8:51 AM, the Administrator reviewed the nursing schedule information and said an RN was not consistently scheduled on day shift.</p>	C 762	<p>schedule when the census raises to above 60 to assure the RN coverage is on the am and pm shift.</p> <p>Audits will be completed weekly X 4 then monthly x 2 . Results will be reported to the QAPI committee monthly for review and remedial interventions.</p> <p>The ED is responsible for monitoring and compliance . The QAPI Committee will re-evaluate the need for further monitoring after 3 months.</p>	
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HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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March 26, 2019

Cindy Riedel, Administrator
Bridgeview Estates
1828 Bridgeview Boulevard
Twin Falls, ID 83301-3051

Provider #: 135113

Dear Ms. Riedel:

On **November 26, 2018** through **December 3, 2018**, an unannounced on-site complaint survey was conducted at Bridgeview Estates in conjunction with an annual Recertification survey. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007526

ALLEGATION:

The facility did not complete a referral for home health care, as ordered, or to the preferred home health provider, resulting in an interruption in the resident's care.

FINDINGS #1:

The clinical records of five residents who were discharged from the facility were reviewed. Interviews were conducted with the Resident Services Director (RSD) in the facility's social services department, the Business Manager for a home health provider, and a resident representative.

One resident's clinical record documented she had used a specific home health provider in the past. It also documented a 4/14/17 physician's order for the resident to discharge with home health physical therapy, occupational therapy, and nursing care. A 4/19/17 progress note by the RSD documented the resident was discharged to home on 4/15/17 and home health had been arranged with the same provider previously used.

Cindy Riedel, Administrator
March 26, 2019
Page 2 of 2

The RSD said she made the referral for home health and faxed information to the home health provider listed in the clinical record. She said she was unaware, and there was no record of a request for a different home health provider. The RSD said she did not document the referral, what information she faxed, or retain the fax confirmation sheet.

The Business Manager with the home health provider listed in the resident's clinical record said they had not received any referral information for her since 2016.

The resident's representative said home health care was not provided after she was discharged from the facility on 4/15/17.

Based on the investigative findings, the allegation was substantiated and deficient practice was cited at tag F 622.

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,



Belinda Day, RN, Supervisor
Long Term Care Program

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TAMARA PRISOCK—ADMINISTRATOR
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April 8, 2019

Cindy Riedel, Administrator
Bridgeview Estates
1828 Bridgeview Boulevard
Twin Falls, ID 83301-3051

Provider #: 135113

Dear Ms. Riedel:

On **December 3, 2018**, an unannounced on-site complaint survey was conducted at Bridgeview Estates. The complaint was investigated in conjunction with the facility's on-site Federal Recertification and State Licensure Survey conducted November 26, 2018 through December 3, 2018. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007671

ALLEGATION #1:

Facility staff did not monitor residents' blood pressure in accordance with professional standards.

FINDINGS #1:

Twenty-two residents were reviewed. Numerous observations were made throughout the facility. Interviews were conducted with residents, the Ombudsman, staff, and family members.

The record of one resident was reviewed who was on an antibiotic for a urinary tract infection with an indwelling urinary catheter. The resident was on blood pressure medication and her blood pressures were monitored. The resident's blood pressure fluctuated from normal to low.

Cindy Riedel, Administrator
April 8, 2019
Page 2 of 5

One blood pressure medication was decreased after low blood pressures. The resident was transported to the hospital appropriately after a below normal blood pressure and altered level of consciousness.

Based on the investigation findings, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Residents were not transported to the hospital upon request of the resident's family member.

FINDINGS #2:

The records for 3 residents were reviewed who were transferred to the hospital for a change in condition with no deficient practice identified.

Resident Council minutes for the previous 6 months were reviewed and no concerns about transfers to the hospital were identified. A Resident council meeting was conducted on 11/28/18 with 10 cognitively intact residents and none of the residents had concerns about delayed transfer.

One resident, whose record was reviewed, had a buildup of fluid around her lungs which was monitored by staff. The fluid buildup potentially required a procedure to drain the fluid from the lungs. The resident's family member was contacted, and the family member requested the resident be transported to the hospital for this procedure if the resident required it. The family member requested a particular physician to do the procedure, however the physician requested was not accepting new patients. The facility notified the family member and the procedure did not get scheduled before she was emergently transferred to the hospital with low blood pressure and altered level of consciousness. There was no other documentation in the resident's record a family member requested the resident be transported to the hospital.

Based on record review, it was determined the allegation could not be substantiated due to lack of sufficient evidence. However, a related deficiency was cited at F622 related to the facility's failure to ensure appropriate information was communicated to another provider upon discharge of the resident.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility failed to return residents' property.

FINDINGS #3:

During the Resident Council meeting on 11/28/18 with 10 cognitively intact residents, no concerns were expressed about missing personal property.

Review of a resident ' s personal effects document was signed and dated by the resident ' s family member. There were two items listed on the inventory list not returned to the family after the resident left the facility. The facility addressed the family member ' s concerns after discharge from the facility.

Based on the investigation findings, it was determined the allegation could not be substantiated due to lack of sufficient evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Residents did not sign their admission paperwork.

FINDINGS #4:

A resident ' s admission record was reviewed. The record included the resident ' s Advance Directives and admission paperwork was signed by the resident.

Other resident ' s admission records were also reviewed, and no deficient practice was identified with admission paperwork.

Based on investigation findings, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

Residents did not have Advanced Directives in their clinical record.

FINDINGS #5:

A Resident Council meeting was conducted on 11/28/18 with 10 cognitively intact residents and none of the residents had concerns about Advance Directives.

A resident record was reviewed for Advance Directives. The resident ' s record documented the admission paperwork was signed by the resident and the record included the Advance Directives.

Review of several other resident ' s records were also reviewed, and no deficient practice was identified.

Based on investigation findings, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The facility failed to maintain appropriate food temperatures.

FINDINGS #6:

The Resident Council was interviewed on 11/28/18. There were no concerns about cold food.

A test tray was sampled by survey staff and the food was palatable and temperatures met regulatory requirements.

Based on investigation findings, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Cindy Riedel, Administrator
April 8, 2019
Page 5 of 5

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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April 10, 2019

Cindy Riedel, Administrator
Bridgeview Estates
1828 Bridgeview Boulevard
Twin Falls, ID 83301-3051

Provider #: 135113

Dear Ms. Riedel:

On **December 3, 2018**, an unannounced on-site complaint survey was conducted at Bridgeview Estates. The complaint was investigated in conjunction with an unannounced federal recertification survey conducted at the facility November 26, 2018 to December 3, 2018. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007813

ALLEGATION #1:

The facility discharged residents inappropriately.

FINDINGS #1:

The clinical records were reviewed for twenty-two residents, including five residents who had been discharged from the facility. Interviews were conducted with multiple residents, three resident representatives, several facility staff, including the Resident Services Director (RSD), and with a home health care agency and an assisted living facility staff.

One resident's clinical record documented he wished to transfer to a lesser care setting and the facility communicated back and forth with an assisted living facility on his behalf. The record also documented the resident changed his mind and decided to stay in the facility.

One resident said he had considered moving to an assisted living setting but decided to stay in the facility.

Another resident's clinical record documented a specific home health care agency had been used in the past. The record included a physician's order for discharge to home when home health services, including physical therapy, occupational therapy, and nursing care, were arranged. A progress note by the RSD documented the resident was discharged and home health services were arranged with the same provider previously used.

The RSD said she made the referral for home health and faxed information to the home health agency listed in the resident's clinical record. The RSD said she did not document the referral to the home health agency, or what information she faxed to the home health, or retain the fax confirmation sheet. The RSD said she was not aware the resident wanted a different home health provider and there was no record of a request for a different home health provider in the resident's clinical record.

The resident representative said home health care was not provided after the resident was discharged from the facility.

The home health staff member said the home health agency did not receive any referral information from the facility for the resident in 2017.

Based on the investigative findings, the allegation was substantiated and deficient practice was cited at F622.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

Residents' clinical records were falsified.

FINDINGS #2:

The clinical records were reviewed for twenty-two residents, including five residents who had been discharged from the facility. Interviews were conducted with multiple residents, three resident representatives, several nurses, the Director of Nursing Services, the Resident Services Director (RSD), and with a home health care agency and an assisted living facility staff.

There was no evidence residents' clinical records were falsified.

Based on the investigative findings, the allegation was not substantiated.

CONCLUSIONS:

Cindy Riedel, Administrator
April 10, 2019
Page 3 of 3

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility did not provide appropriate wound care.

FINDINGS #3:

The clinical records were reviewed for twenty-two residents, including 3 residents who had skin wounds. Interviews were conducted with residents, nurses, the Director of Nursing Services, and with an assisted living facility staff member.

One resident said, and his clinical record documented, he frequently refused wound care and sometimes picked at the wounds on his legs. The resident was independent and able to make his own decisions. His care plan identified the non-compliance and picking, and included interventions to help minimize, or reduce, the risk associated with the behaviors.

The provision of wound care was observed for three residents and deficient practice was not identified.

Based on the investigative findings, the allegation was not substantiated.

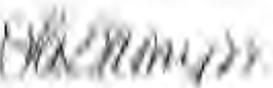
CONCLUSIONS:

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



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April 12, 2019

Cindy Riedel, Administrator
Bridgeview Estates
1828 Bridgeview Boulevard
Twin Falls, ID 83301-3051

Provider #: 135113

Dear Ms. Riedel:

On **December 3, 2018**, an unannounced on-site complaint survey was conducted at Bridgeview Estates. The complaint was investigated in conjunction with an annual federal recertification conducted from November 26, 2018 through December 3, 2018. The complaint allegations findings and conclusions are as follows:

Complaint #ID00007955

ALLEGATION:

The facility failed to provide appropriate rehabilitation and mobility devices to residents.

FINDINGS:

Sixteen residents were reviewed. Numerous observations were made throughout the facility. Interviews were conducted with residents, the Ombudsman, staff, and family members. Resident Council minutes for the previous 6 months were reviewed, and no concerns were identified about residents' rehabilitation services or mobility devices. A Resident Council meeting was conducted on 11/28/18 with 10 cognitively intact residents and none of the residents had concerns with their physical or occupational therapies.

Cindy Riedel, Administrator
April 12, 2019
Page 2

Review of a resident's record who was admitted for rehabilitation after a wound vacuum (a device to help wounds heal) was placed to a lower extremity in the hospital. The physician's order specified the resident was not to bear weight on the extremity. The orders also included the resident was to receive physical and occupational therapy. There was no documentation in the resident's record the resident did not receive physical and occupational therapy as ordered.

Review of a resident's record for use of a mobility device had no documentation the resident did not have access to the appropriate mobility device.

Based on the investigation findings, it was determined the allegation could not be substantiated due to lack of sufficient evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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

Sincerely,

A handwritten signature in cursive script, appearing to read "Belinda Day".

Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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June 4, 2019

Cindy Riedel, Administrator
Bridgeview Estates
1828 Bridgeview Boulevard
Twin Falls, ID 83301-3051

Provider #: 135113

Dear Ms. Riedel:

On **November 26, 2018** through **December 3, 2018**, an unannounced on-site complaint survey was conducted at Bridgeview Estates. The complaint survey was conducted in conjunction with the annual recertification survey.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007734

ALLEGATION #1:

Residents were not provided adequate supervision to prevent falls.

FINDINGS #1:

Sixteen residents were reviewed during the investigation. Numerous observations were made throughout the facility. Interviews were conducted with residents, the Ombudsman, multiple staff members, and at least three family members. Resident Council Minutes for the previous 6 months were reviewed and no like concerns were identified. A Resident Council meeting was conducted on 11/28/18 with 10 residents, and none of the residents had concerns regarding inadequate supervision to prevent falls. Incident and Accident reports as well as grievances were reviewed for a six month look back period with no concerns identified.

Review of one resident's record documented the resident had moderate cognitive impairment and

Cindy Riedel, Administrator
June 4, 2019
Page 2 of 6

required extensive assistance of staff for transfers, toileting nad hygiene. The resident could feed herself with supervision and cueing, after meals were set up by staff. Review of the resident's Care Plan included interventions for falls, pain, nutrition, incontinence of bowel and bladder, weakness, and dementia/confusion.

Review of 5 facility investigations related to falls documented appropriate investigation, treatment and interventions after the falls, including neurological checks, notification to family, and referral to a restorative nursing program for one resident to assist with safe transfers and placing the resident's bed in the low position.

Due to investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Facility staff did not answer residents' call light in a timely manner.

FINDINGS #2:

During the investigation, all residents were questioned regarding call lights and prompt delivery of care. No concerns were identified. No call light concerns were voiced by residents in attendance for the Resident Council meeting. Call light audits were conducted during the investigation and no excessive wait times for care were identified.

Due to investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Staff left a resident on the toilet for up to 45 minutes.

FINDINGS #3:

Resident records were reviewed and direct observations made. There were no observations or records to indicate residents had been left on the toilet for an excessive amount of time.

Residents were interviewed and none of the residents had complaints of being left unattended in the bathroom.

Due to investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Residents were not provided a diet that was consistent with physician orders.

FINDINGS #4:

During the survey there were no concerns about residents not receiving nutritional supplements and diets as ordered by the physician.

Review of one resident's record had orders for nutritional supplements to improve nutritional status. The resident's record had subsequent orders for a protein enriched diet, and to include offering meat and eggs twice a day. Review of the resident's dietary "Eating/Drinking" report indicated the resident was on a protein enhanced diet with supplements, but frequently ate only 25% of her meals. The resident's supplement intake was 25-50% of supplements offered.

Due to investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

Residents did not receive their meal tray during mealtimes.

FINDINGS #5:

During the survey, there were no observations of residents not receiving their meal tray during mealtimes.

Review of one resident's record who was on a protein enhanced diet with supplements, did not include documentation of the resident not receiving meal trays. Review of the resident's "Eating/Drinking" report for the period documented the resident frequently ate only 25% of meals. The resident's supplement intake was 25-50% of supplements offered.

Due to investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The facility failed to prevent infections in residents.

FINDINGS #6:

The investigation included observations of resident rooms, bathrooms, and common areas throughout the five-day survey. No concerns with uncleanliness were identified. The housekeepers were observed cleaning throughout the facility each day of the survey. No concerns were verbalized by the interviewable residents in attendance for the Resident Council meeting and several of the residents commented "they keep it clean here ..."

Review of one resident's record diagnosed with an infection documented the resident placed on oral antibiotics and moved to a private room and placed on isolation to prevent the spread of infection to other residents. There were no current residents on infectious precautions during the survey, so no direct observations could be made.

Due to investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

Residents were not transferred in a timely manner and did not have correct Preadmission Screening and Resident Review (PASRR) information.

FINDINGS #7:

During the survey, there was no documentation or concerns regarding resident transfer delays or incorrect screening information.

The investigation included a review of a resident's Preadmission Screening and Resident Review. No concerns were identified. There was no documentation in the record to indicate the resident was to be transferred to another long-term care facility prior to the date of discharge.

An interview with the Administrator did not indicate transfers were delayed. Transfer documentation reviewed with the Administration did not include a delay in transfer.

Due to investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

Facility staff did not follow physician orders regarding resident positioning.

FINDINGS #8:

During the survey, there were no observations or complaints regarding resident's not receiving positioning as ordered by the physician.

One resident's record was reviewed who had orders for leg positioning and to wear compression stockings for edema. An interview with the Administrator confirmed the resident had severe edema and was frequently non-compliant with orders to elevate the legs and wear the compression stockings as ordered. Review of the facility's investigation report regarding positioning after the resident was discharged, did not include evidence to substantiate the concerns.

Due to investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Cindy Riedel, Administrator
June 4, 2019
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Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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

Sincerely,

A handwritten signature in cursive script, appearing to read "Belinda Day".

Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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June 18, 2019

Cindy Riedel, Administrator
Bridgeview Estates
1828 Bridgeview Boulevard Twin Falls, ID 83301-3051

Provider #: 135113

Dear Ms. Riedel:

On **December 3, 2018**, an unannounced on-site complaint survey was conducted at Bridgeview Estates. Four investigators conducted the investigation in conjunction with the annual recertification survey on **November 26, 2018** through **December 3, 2018**.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007912

ALLEGATION #1:

The facility failed to ensure residents were appropriately groomed and dressed when going out of the facility to appointments.

FINDINGS #1:

Sixteen residents were reviewed, observations were made throughout the facility, and interviews were conducted with residents, the Ombudsman, staff members, and at least three family members.

A Resident Council meeting was conducted on 11/28/18 with 10 residents and none of the residents had concerns about abuse or neglect.

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June 18, 2019
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During an interview with one resident who went out of the facility for appointments, said she liked to get up only to go to the hairdresser once a week. The resident did not have concerns about being groomed and dressed when she left the facility for appointments.

Observations of residents were made from 11/26/18 through 11/30/18 and there were no observations of residents not being clean and groomed.

Facility policies for Abuse and Neglect were noted to be implemented.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility failed to ensure residents were free from abuse.

FINDINGS #2:

Observations were made throughout the facility, interviews were conducted with residents, the Ombudsman, staff members, and 3 family members. There were no concerns regarding abuse.

The Resident Council Minutes for the previous 6 months were reviewed and there were no concerns about abuse were documented. During the Resident Council Meeting on 11/28/2018 with 10 residents, there were no complaints about staff not ensuring residents were free from abuse.

Due to investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Residents were not able to keep scheduled appointments outside the facility due to a lack of transportation.

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FINDINGS #3:

In an interview with the facility's transporter, she said recently one resident was not on the schedule for an appointment, so transportation was not arranged. The transporter said that in the past there were missed appointments, but since she started the job a new process was implemented including a contract with a transport company to use if necessary.

Review of one resident's current record identified multiple appointments outside of the facility including a wound care clinic. There were no complaints about transportation during the survey from resident and family interviews or from the Resident Council meeting. The facility had a van for transporting residents and used a contractor if necessary

Review of another resident's record documented the resident was being transported to dialysis three times a week without issues.

Based on survey findings, the allegation was substantiated without citation, due to being an isolated incident with no current deficient practice.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

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

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

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj