



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P. O. Box 83720
Boise, Idaho 83720-0009
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January 15, 2020

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

Provider #: 135139

Dear Mr. Strong:

On **January 9, 2020**, a survey was conducted at Riverview Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed.

NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **January 27, 2020**. Failure to submit an acceptable PoC by **January 27, 2020**, may result in the imposition of penalties by **February 17, 2020**.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **February 13, 2020 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **April 9, 2020**. A change in the seriousness of the deficiencies on **February 23, 2020**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **April 9, 2020** includes the following:

Denial of payment for new admissions effective **April 9, 2020**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 9, 2020**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Belinda Day, RN or Laura Thompson, RN, Supervisors Long Term Care, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **April 9, 2020** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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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 27, 2020**. If your request for informal dispute resolution is received after **January 27, 2020**, 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 Belinda Day, RN, or Laura Thompson, 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2020
NAME OF PROVIDER OR SUPPLIER RIVERVIEW REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 WEST AMERICANA TERRACE BOISE, ID 83706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted on January 6, 2020 through January 9, 2020. The surveyors conducting the survey were: Jenny Walker, RN, Team Coordinator Robin Tuiskula, RN Abbreviations: DNS = Director of Nursing LPN = Licensed Practical Nurse MDS = Minimum Data Set	F 000			
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.	F 622		2/14/20	

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

TITLE

(X6) DATE

Electronically Signed

01/27/2020

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 622	<p>Continued From page 1</p> <p>Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or</p> <p>(F) The facility ceases to operate.</p> <p>(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.</p> <p>§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(i) Documentation in the resident's medical record must include:</p> <p>(A) The basis for the transfer per paragraph (c) (1)(i) of this section.</p> <p>(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving</p>	F 622			

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F 622	<p>Continued From page 2 facility to meet the need(s).</p> <p>(ii) The documentation required by paragraph (c) (2)(i) of this section must be made by-</p> <p>(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and</p> <p>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.</p> <p>(iii) Information provided to the receiving provider must include a minimum of the following:</p> <p>(A) Contact information of the practitioner responsible for the care of the resident.</p> <p>(B) Resident representative information including 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 staff interview and record review, it was determined the facility failed to ensure information was provided to the receiving hospital for emergent situations for 2 of 4 residents (#7 and #13) reviewed for transfers. This deficient practice had the potential to cause harm if the resident was not treated in a timely manner due to lack of information. Findings include:</p> <p>1. Resident #7 was readmitted to the facility on 12/20/19, with multiple diagnoses including heart failure and chronic obstructive pulmonary</p>	F 622	<p>Residents' Affected: Resident #7 Discharged on 01/17/2020. Resident #13 Discharged on 01/20/2020.</p> <p>Residents' with the potential to be affected: A review of residents transferred out with an expected return was conducted by the Director of Nurses or Designee on or before 02/11/2020 to ensure necessary documentation and information was provided to the transport staff members, emergency departments,</p>		

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F 622	<p>Continued From page 3</p> <p>disease (affects the lungs and causes reduced airflow).</p> <p>A discharge MDS assessment, dated 12/18/19, documented Resident #7 was discharged to an acute care hospital.</p> <p>A Hospital Transfer Form, dated 12/18/19 at 10:20 AM, documented Resident #7 was transferred to the hospital for new or worsening edema (swelling) and the nurse practitioner gave a verbal report to the hospital.</p> <p>A Physician Progress Note, dated 12/18/19 at 10:21 AM, documented Resident #7 had a change of condition and ordered him to be transferred to the Emergency Department for further evaluation.</p> <p>A Nurse's Progress Note, dated 12/18/19 at 10:33 AM, documented Resident #7 was sent to the hospital for evaluation.</p> <p>Resident #7's record did not document information regarding who transported him to the hospital. Resident #7's record did not include documentation information was provided to the transportation staff members and the Emergency Department to ensure a safe and effective transition of care.</p> <p>On 1/8/20 at 3:07 PM, the DNS stated Resident #7's record did not include documentation the Hospital Transfer Form and paperwork were provided to the transport staff members.</p> <p>2. Resident #13 was readmitted to the facility on 1/1/20, with multiple diagnoses including a</p>	F 622	<p>other receiving health care institutions, or providers. Follow-up including re-education of Licensed Nurse Staff will be completed as indicated.</p> <p>Systematic Change/Education: Licensed Nurse Staff will be educated by the Director of Nurses or Designee on or before 02/11/2020 on providing complete and necessary documentation and information for residents transferred out of the facility with an expected return. Documentation and information will be provided to any transport staff members, emergency departments, other receiving health care institutions, or providers. Documentation required but not limited to; face sheet, current labs, medical director and/or nurse practitioner notes, licensed nurse notes, current medication list, advanced directives, medical director and nurse practitioner contact form (Physician that has assumed care), and licensed nurse staff, MD, or Nurse Practitioner who called resident report to receiving institution.</p> <p>Beginning the week of 02/10/2020, Licensed Nurse Staff will inform Director of Nurses, Nurse Manager, or on-call Nurse when a resident is being transferred out of the facility (with an expected return) to any Emergency Department, other receiving health care institution, or provider to ensure that necessary documentation and information is being provided as required.</p>		

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F 622	Continued From page 4 perforated (pierced with a hole) gall bladder. A discharge MDS assessment, dated 12/27/19, documented Resident #13 was discharged to an acute care hospital. A Nurse's Progress Note, dated 12/27/19 at 8:20 PM, documented Resident #13's laboratory results were abnormal and the physician ordered to send him to the Emergency Department for further evaluation. The note documented he was transported via ambulance to the Emergency Department. Resident #13's record did not include documentation information was provided to the paramedics and the Emergency Department to ensure a safe and effective transition of care. On 1/9/20 at 9:37 AM, the DNS stated the Hospital Transfer Form for Resident #13 was not filled out when he was transferred to the hospital on 12/27/19. The DNS stated Resident #13's record did not include documentation the paperwork was provided to the paramedics and the Emergency Department he was sent to for evaluation.	F 622	Beginning the week of 02/10/2020, residents that were transferred out of the facility (with an expected return) to any emergency department, other receiving health care institutions, or providers, will be reviewed in morning clinical meeting by IDT to ensure necessary documentation and information was provided. Monitoring: Beginning the week of 02/10/2020, an audit will be completed by the Director of Nurses or Designee to ensure necessary documentation and information was provided to transport staff members, emergency departments, other receiving health care institutions, or providers for residents transferred out with an expected return. These audits will be completed weekly X4 weeks and monthly X2 months. The results of these audits will be reported to the QAPI Committee monthly X3 months or until substantial compliance is achieved. The Director of Nurses is responsible for monitoring and oversight.		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		2/14/20	

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F 684	<p>Continued From page 5 care plan, and the residents' choices. 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 physician orders and care plans were followed for 1 of 12 residents (Resident #7) who were reviewed for standards of practice. This failed practice had 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>Resident #7 was admitted to the facility on 11/26/19, with multiple diagnoses including weakness, cirrhosis of the liver, and alcohol abuse.</p> <p>Resident #7's care plan, dated 11/27/19, documented Resident #7 was at risk for altered safety related to alcohol consumption. The interventions directed staff to educate Resident #7 about the negative impacts of excessive alcohol and to encourage him to abstain from alcohol consumption while in the facility.</p> <p>Resident #7's physician's orders did not include orders for him to have alcohol.</p> <p>On 1/7/20 at 4:15 PM, Resident #7 was observed sitting at a table drinking a beer during happy hour at the facility.</p> <p>On 1/7/20 at 4:45 PM, Resident #7 was observed sitting at the table drinking a second beer.</p> <p>On 1/7/20 at 5:10 PM, the Activity Assistant</p>	F 684	<p>Residents' Affected: Resident #7 discharged on 01/17/2020.</p> <p>Residents' with the potential to be affected: A review of residents physician orders and care plans will be conducted by the Director of Nurses or Designee on or before 02/11/2020 to ensure physician orders and care plans were followed in accordance with professional standards of practice, comprehensive person-centered care plan, and residents choice. Follow-up and order reconciliation will be completed as indicated by the Director of Nurses or Designee.</p> <p>Systematic Change/Education: Licensed Nurse Staff will be educated by the Director of Nurses or Designee on or before 02/11/2020 on following physician orders and following care plans to ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents choices.</p> <p>Beginning the week of 02/10/2020, a review of new physician orders and pertaining care plans will be reviewed in morning clinical meeting by IDT. The Director of Nurses or Designee will validate that physician orders are accurate and care plans are updated to ensure facility staff follow physician</p>		

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F 684	<p>Continued From page 6</p> <p>stated the facility provided happy hour from 4:00 PM to 5:00 PM, twice a week for the residents. The activity assistant stated she served beer, wine, and soda to the residents.</p> <p>On 1/7/20 at 5:19 PM, Resident #7 was back in his room and stated he had two beers during the happy hour activity. Resident #7 stated he requested a third beer in his room and was told he could not have alcohol in his room.</p> <p>On 1/7/20 at 5:30 PM, the Activity Assistant stated the floor nurse or the DNS notified her of residents who were not allowed to have alcohol when they were admitted to the facility. The Activity Assistant stated LPN #1 came down to the dining room to visit another resident and noticed Resident #7 was there and instructed her to not serve Resident #7 anymore alcohol. The Activity Assistant stated she limited the residents to two beers for each happy hour. The Activity Assistant stated she did not talk to LPN #1 prior to Resident #7 attending happy hour. The Activity Assistant stated she did not look in residents' records to see if they could have alcohol. The Activity Assistant stated she did not know Resident #7 should not have alcohol. The Activity Assistant stated she did not report to the floor nurse who attended happy hour and what each resident consumed.</p> <p>On 1/7/20 at 5:30 PM, LPN #1 stated Resident #7 did not have a physician's order for alcohol and he should not have had alcohol because of his history of alcohol abuse. LPN #1 stated she was unaware Resident #7 attended happy hour until she went down to the dining room to see another resident and saw Resident #7 sitting at</p>	F 684	<p>orders, the plan of care, and honor resident choice.</p> <p>Monitoring: Beginning the week of 02/10/2020, an audit will be completed by the Director of Nurses or Designee to ensure residents physician orders and care plans are followed in accordance with professional standards of practice, comprehensive person-centered care plan, and resident's choice. These audits will be completed weekly X4 weeks and monthly X2 months. The results of these audits will be reported to the QAPI Committee monthly X3 months or until substantial compliance is achieved. The Director of Nurses is responsible for monitoring and oversight.</p>		

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

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F 684	Continued From page 7 the table finishing a beer. LPN #1 was not aware Resident #7 consumed two beers within the hour. On 1/8/20 at 9:55 AM, the DNS stated Resident #7 did not have a physician's order for alcohol. The DNS stated the Activity Assistant should have reported to the floor nurse every resident that attended happy hour and what they consumed. On 1/8/20 at 10:00 AM, the Nurse Practitioner stated Resident #7 should not have had the two beers without a physician's order.	F 684			