



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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April 12, 2019

Randal Barnes, Administrator
Valley View Nursing & Rehabilitation
1140 North Allumbaugh Street
Boise, ID 83704-8700

Provider #: 135098

Dear Mr. Barnes:

On **March 29, 2019**, a survey was conducted at Valley View Nursing & Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

Randal Barnes, Administrator
April 12, 2019
Page 2

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 22, 2019**. Failure to submit an acceptable PoC by **April 22, 2019**, may result in the imposition of penalties by **May 15, 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*.

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 **May 3, 2019 (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 **June 29, 2019**. A change in the seriousness of the deficiencies on **May 13, 2019**, may result in a change

Randal Barnes, Administrator
April 12, 2019
Page 3

in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 29, 2019** includes the following:

Denial of payment for new admissions effective **June 29, 2019**. [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 **September 29, 2019**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Belinda Day, RN or Laura Thompson, RN, Supervisors LTC, 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 **June 29, 2019** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

Randal Barnes, Administrator
April 12, 2019
Page 4

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

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

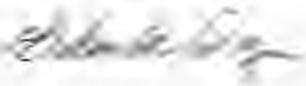
- BFS Letters (06/30/11)

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

This request must be received by **April 22, 2019**. If your request for informal dispute resolution is received after **April 22, 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 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

bd/dr

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

PRINTED: 04/29/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/29/2019
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NAME OF PROVIDER OR SUPPLIER VALLEY VIEW NURSING & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1140 NORTH ALLUMBAUGH STREET BOISE, ID 83704
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted from 3/25/19 through 3/29/19.</p> <p>The surveyors conducting the survey were: Cecilia Stockdill, RN, Team Coordinator Presie Billington, RN Karen George, RN Patricia Hinson, RN</p> <p>Survey Abbreviations:</p> <p>CNA = Certified Nursing Assistant COPD = Chronic Obstructive Pulmonary Disease DON = Director of Nursing DNR = Do Not Resuscitate IDT = Interdisciplinary Team IV = intravenous LPN = Licensed Practical Nurse MDS = Minimum Data Set assessment POST = Physician Orders for Scope of Treatment RN = Registered Nurse SW = Social Worker</p>	F 000		
F 578 SS=E	<p>Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)</p> <p>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary</p>	F 578		4/30/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 04/22/2019
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 578	Continued From page 1 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. (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. (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. (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. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, resident interview, and staff interview, it was determined the facility failed to ensure residents' records documented an Advance Directive was present or documented the resident did not wish to formulate an Advance Directive, and the Advance	F 578	F578 1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.		

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F 578	<p>Continued From page 2</p> <p>Directive was complete. This was true for 8 of 14 residents (Residents #11, #13, #26, #31, #36, #37, #49, and #181) whose records were reviewed for Advance Directives. These failures created the potential for harm should residents not have their decisions honored and respected if they were unable to make or communicate their health care preferences. Findings include:</p> <p>The facility's policy for Advance Directives, dated 2018, documented the following upon admission, residents were provided written information regarding their right to formulate an Advance Directive. Prior to or upon admission, the Social Services Director or appointee inquired of residents whether a written Advance Directive existed and information about whether the resident executed an Advance Directive was "displayed prominently" in the resident's record. The policy stated if the resident did not have an Advance Directive, facility staff offered assistance to establish one and nursing staff documented the resident was offered assistance and whether they accepted or declined assistance.</p> <p>This policy was not followed.</p> <p>1. Resident #13 was readmitted to the facility on 7/12/17, with multiple diagnoses including severe sepsis (a potentially life-threatening condition caused by the body's response to an infection) and left bundle branch block (a delay or blockage along the pathway that electrical impulses travel to make the heart beat).</p> <p>Resident #13's quarterly MDS assessment, dated 12/25/18, documented she was cognitively intact.</p>	F 578	<p>-SSD formulated an advanced directive for resident's #11, #13, #26, #31, #36, #37, and #49 immediately.</p> <p>-Resident #181 has since been discharged and passed away therefore facility unable to correct deficient practice.</p> <p>2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>-SSW and designee did an audit of all current residents for completion of advanced directives and no other residents were affected by the deficient practice.</p> <p>3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.</p> <p>-Administrator in-serviced Social Services personnel and the Admissions Coordinator on the importance of advanced directives being identified and copies obtained prior to admission; discussion with resident or their representative on their right to formulate advanced directives and receive assistance in formulating; should resident decline to formulate advanced directives then documentation to support the decline; ensuring the advanced directive paperwork presented and/or completed</p>		

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F 578	<p>Continued From page 3</p> <p>Resident #13's Living Will and Durable Power of Attorney (DPOA) for Health Care documented "In such event, I direct that the following marked expressions of my intent be followed, and that I receive any medical treatment or care that may be required to keep me free of pain or distress. Check one box and initial the line after such box:" There was one choice given under this statement, and the box was not marked to indicate her wishes, and there were no initials on the signature line.</p> <p>Resident #13's IDT Care Plan Conference/ Welcome Meeting Form, dated 12/13/18 at 2:05 PM, did not include documentation her Living Will and DPOA was reviewed and discussed.</p> <p>On 3/29/19 at 10:00 AM, the DON said she did not see initials or a box checked on Resident #13's Living Will that indicated her wishes.</p> <p>The facility did not provide documentation of a completed Advance Directive or that the Advance Directive was reviewed and discussed with Resident #13.</p> <p>2. Resident #36 was admitted to the facility on 4/16/18, with multiple diagnoses including Alzheimer's disease and COPD (a progressive lung disease that results in shortness of breath).</p> <p>Resident #36's quarterly MDS assessment, dated 1/24/19, documented he had severe cognitive impairment.</p> <p>Resident #36's physician orders documented "DNR" was ordered on 4/17/18.</p>	F 578	<p>has been appropriately completed.</p> <p>-SSW was in-serviced to review resident's advanced directives during their quarterly care conference in case of any changes or errors and document the discussion in the case that resident refuses.</p> <p>-Admin in-serviced Admissions Coordinator on the importance of advanced directives being signed prior to or upon admission.</p> <p>Care plan was created on admission to identify if Advanced directive has been formulated.</p> <p>4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur.</p> <p>-Administrator or Designee will conduct an audit on all admissions 2 x weekly 12 to ensure residents records documented an advance directive was present or documentation of refusal and brought to the monthly QAPI meeting with any identified negative trends addressed through system modification and staff education as appropriate.</p>		

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F 578	<p>Continued From page 4</p> <p>Resident #36's IDT Care Plan Conference/ Welcome Meeting Form, dated 8/2/18 at 9:11 AM, did not include documentation an Advance Directive was reviewed and discussed.</p> <p>On 3/29/19 at 10:17 AM, Resident #36's record was reviewed with the DON. There was no documentation of an Advance Directive or that it was offered or discussed with Resident #36 or his guardian. The DON said there was documentation Resident #36 had an appointed guardian, and she thought Resident #36's guardian could make healthcare decisions for him.</p> <p>The facility did not provide documentation of an Advance Directive or that it was offered or discussed with Resident #36 or his guardian.</p> <p>3. Resident #37 was readmitted to the facility on 7/28/18, with multiple diagnoses including multiple sclerosis and dementia.</p> <p>Resident #37's DPOA was signed by her on 6/24/11. The DPOA did not include documentation regarding her end of life decisions or wishes. The checkbox and signature line were blank next to each choice offered regarding her wishes for end of life medical treatment.</p> <p>Resident #37's care plan, initiated on 9/21/16 and revised on 7/5/18, documented her code status was Full Code.</p> <p>Resident #37's IDT Care Plan Conference/ Welcome Meeting Form, dated 11/30/18 at 12:00 PM, did not include documentation her DPOA was reviewed and discussed with her.</p>	F 578			

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F 578	<p>Continued From page 5</p> <p>On 3/29/19 at 9:46 AM, the DON said she did not see any boxes checked on Resident #37's DPOA to indicate her wishes for end of life medical treatment. The DON said if a resident started to look like they were terminal, if there was a change of condition, if the resident was a nutritional risk and still losing weight, then the facility had a discussion about their Advanced Directive. The DON said she also referred to the POST. The DON said Resident #37 was still able to make healthcare decisions.</p> <p>The facility did not provide documentation of a completed DPOA for Resident #37, or that an Advance Directive was reviewed and discussed with her.</p> <p>4. Resident #49 was admitted to the facility on 1/11/19, with multiple diagnoses including sepsis (severe infection), acute embolism and thrombosis (blood clot) of the right lower extremity, heart block (abnormal heart rhythm where the heart beats too slowly), and a cardiac pacemaker.</p> <p>Resident #49's significant change MDS assessment, dated 2/18/19, documented she had moderate cognitive impairment.</p> <p>On 3/28/19 at 8:30 AM, the facility provided a written note that documented no Advance Directives were documented for Resident #49.</p> <p>Resident #49's record did not include documentation of an Advance Directive, or documentation Advance Directives were discussed with her.</p>	F 578			

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F 578	<p>Continued From page 6</p> <p>On 3/29/19 at 9:55 AM, the DON said the list provided by the facility documented Resident #49 did not have an Advance Directive.</p> <p>5. Resident #31 was admitted to the facility on 1/16/19, with multiple diagnoses including COPD.</p> <p>An admission MDS assessment, dated 1/16/19, documented Resident #31 was moderately cognitively intact.</p> <p>Resident #31's physician orders documented a code status of DNR was ordered on 1/18/19.</p> <p>Resident #31's care plan, initiated on 1/16/19, documented he had a code status of DNR.</p> <p>An Advance Directive policy form was signed by Resident #31 on 1/17/19, but the question about an Advance Directive, which documented whether he was informed of how to obtain an Advance Directive and would provide a copy of any Advance Directive that he had in place, was not answered.</p> <p>On 3/29/19 at 10:08 AM, the Medical Record Director said she was unable to find Resident #31's IDT Care Plan Conference/Welcome Meeting Form.</p> <p>6. Resident #181 was readmitted to the facility on 9/11/17, with multiple diagnoses including multi-system degeneration of the autonomic nervous system (a neurological disorder affecting the body's involuntary functions, including blood pressure, bladder function and muscle control).</p>	F 578			

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F 578	<p>Continued From page 7</p> <p>Resident #181's quarterly MDS assessment, dated 6/6/18, documented she was cognitively intact.</p> <p>Resident #181's physician orders documented a code status of DNR was ordered on 12/21/17.</p> <p>Resident #181's IDT Care Plan Conference/ Welcome Meeting, dated 6/14/18 at 1:00 PM, did not include documentation the Advance Directive was discussed with Resident #181 or her representative.</p> <p>On 3/29/19 at 2:10 PM, the DON said there was no documentation in Resident #181's record that the Advance Directive was discussed or reviewed with her or her representative.</p> <p>7. Resident #11 was readmitted to the facility on 3/14/18, with multiple diagnoses including hypertension (high blood pressure) and heart failure.</p> <p>Resident #11's quarterly MDS assessment, dated 12/22/18, documented she was cognitively intact.</p> <p>Resident #11's IDT Care Plan Conference/ Welcome Meeting, dated 9/21/18, documented a POST was completed, and an Advance Directive was not completed. Resident #11's record documented the Advanced Directive was reviewed and discussed on 10/4/18, 1/7/19, and 1/31/19, as indicated by a checked box. The documentation did not provide details of the information that was reviewed and discussed regarding Advance Directives and did not document Resident #11 declined the opportunity to learn more about Advance Directives or to</p>	F 578			

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F 578	<p>Continued From page 8 develop an Advance Directive.</p> <p>8. Resident #26 was readmitted to the facility on 6/28/18, with multiple diagnoses including atherosclerotic heart disease (hardening and narrowing of the arteries).</p> <p>Resident #26's quarterly MDS assessment, dated 1/19/19, documented she was cognitively intact.</p> <p>Resident #26's IDT Care Plan Conference/ Welcome Meeting, dated 3/8/18, 10/5/18, and 12/31/18, documented the Advance Directive was reviewed and discussed as indicated by a checked box. The documentation did not provide details of the information that was reviewed and discussed with Resident #26 regarding an Advance Directive, and did not document Resident #26 declined the opportunity to learn more about an Advance Directive or to develop an Advance Directive.</p> <p>On 3/29/19 at 11:21 AM, Resident #26 said she could not recall the facility educating her regarding an Advance Directive. She said the only thing she remembered was being asked if she wanted to be resuscitated, to which she said no.</p> <p>On 3/27/19 at 2:33 PM, the DON, Admissions Coordinator, and Social Worker said the Welcome Conference documented an Advance Directive was discussed with Resident #26, and it was reviewed quarterly at each IDT meeting.</p> <p>On 3/27/19 at 9:27 AM, the DON said the facility used to be managed by another company, and she thought the management company did not</p>	F 578			

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

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER VALLEY VIEW NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1140 NORTH ALLUMBAUGH STREET BOISE, ID 83704		
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F 578	Continued From page 9 cover the topic of Advance Directives in the admission paperwork. The DON provided an Advance Directive policy from the current management company, but the policy was not effective during the admission dates of Resident #11 and Resident #26. The DON said the facility did not have a policy covering the topic of POA. On 3/27/19 at 2:17 PM, the Admissions Director, with the DON and SW #1, said residents were asked upon admission if they had an Advance Directive, and they were asked for a copy if they had one. If the resident did not have an Advance Directive, they were offered help to complete one. SW #1 said Advanced Directives and POST were discussed with the residents during their care conferences and they were reviewed quarterly. The DON said the IDT Care Plan Conference/Welcome Meeting Form had a checklist of what was reviewed with the residents and it included the Advanced Directive. On 3/27/19 at 2:22 PM, the DON and SW #1 said the POST was part of the Advance Directive. SW #1 said the POST and Advance Directive were included verbally in the care conference and the code status was reviewed every quarter in the care conference note.	F 578			
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and	F 582		4/30/19	

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F 582	<p>Continued From page 10</p> <p>for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.</p> <p>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.</p> <p>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.</p> <p>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.</p> <p>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</p> <p>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's</p>	F 582			

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F 582	<p>Continued From page 11 date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents were provided with an Advanced Beneficiary Notice at the initiation, reduction, or termination of their Medicare Part A benefits. This was true for 1 of 3 residents (Resident #182) reviewed for Advance Beneficiary Notice (ABN). This failure created the potential for residents to experience financial and psychological distress when residents were not informed of their potential liability for payment. Findings include:</p> <p>Resident #182 was admitted to the facility on 12/4/18, with multiple diagnoses including heart failure and stroke.</p> <p>On 3/28/19 at 10:28 AM, SW #2 was asked to complete Resident #182's Skilled Nursing Facility Beneficiary Protection Notification Review form.</p> <p>On 3/29/19 at 1:31 PM, the SW #2 said she believed they gave the ABN form to Resident #182 and it was submitted to the Business Office to be included in Resident #182's record. SW #2 said she was unable to find Resident #182's ABN form.</p>	F 582	<p>F582</p> <p>1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>-Resident #182 has discharged from the facility. Unable to correct the deficiency for this resident.</p> <p>2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>-An Audit was done on all Part A residents for completion of the ABN and no other residents were affected by the deficient practice.</p> <p>3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.</p> <p>-In-Service was done with SSW to ensure ABN is issued at the initiation, reduction, or termination of their Medicare Part A benefits.</p>		

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F 582	Continued From page 12	F 582	A form was created for our daily PPS meeting that will prompt us to have the ABN form given at the initiation, reduction or termination of their Part A benefits. 4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur. -An Audit will be done weekly x 12 by the RAC to ensure all Part A resident have received the ABN forms when necessary and results will be brought to the monthly QAPI meeting with any identified negative trends addressed through system modification and staff education as appropriate.		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F 585		4/30/19	

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F 585	Continued From page 13 §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and	F 585			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 585	Continued From page 14 coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on policy review, record review, review of	F 585			
			F585		

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F 585	<p>Continued From page 15</p> <p>grievances, and family representative interview, it was determined the facility failed to ensure grievances were responded to and investigated, and prompt corrective action was taken to resolve grievances. This was true for 1 of 19 residents (Resident #181) reviewed for grievances. This failure created the potential for harm if the resident's grievance was not acted upon and the resident did not receive appropriate care. Findings include:</p> <p>The facility's undated Grievances/Complaints policy documented the resident, or person acting on behalf of the resident, was notified of the findings of the investigation and any corrective actions recommended within 5 working days of the filing of the grievance or complaint.</p> <p>Resident #181 was readmitted to the facility on 9/11/17, with multiple diagnoses including multi-system degeneration of the autonomic nervous system (a neurological disorder affecting the body's involuntary functions, including blood pressure, bladder function and muscle control).</p> <p>Resident #181's quarterly MDS assessment, dated 6/6/18, documented she was cognitively intact and she required extensive assistance of 1 to 2 staff members for her activities of daily living.</p> <p>A Resident Grievance report documented Resident #181's family representative filed a grievance on 5/11/18 and on 6/25/18. The grievances were as follows:</p> <p>a. The Grievance report, dated 5/11/18, documented Resident #181 was not provided with showers, she was forced to eat, and staff</p>	F 585	<p>1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>-Resident #181 has discharged from the facility. Unable to correct the deficiency for this resident.</p> <p>2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>-An audit of all grievances of 2019 was done and no other residents were affected by the deficient practice.</p> <p>3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.</p> <p>-In-service was given to the SSW on our policy of resolving grievances and notifying the origin of the grievance as well with their responsible party.</p> <p>- New Grievance form was created that prompts the SSW to notify the resident's responsible party to make sure they are satisfied with the plan of care and resolution of the grievance being made.</p> <p>4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is</p>		

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F 585	<p>Continued From page 16</p> <p>were not knowledgeable about her disease condition.</p> <p>The Grievance report documented Resident #181's clinical record was reviewed, and it included documentation showers were provided to her. Staff were in-serviced on dignity, cleaning resident's face and hands after eating, and on Resident #181's disease process and condition.</p> <p>Resident #181's Grievance report did not include documentation her family representative was notified of the resolution of their grievance or they received a report of the facility's investigative findings.</p> <p>b. A Grievance report, dated 6/25/18, documented the following:</p> <ul style="list-style-type: none"> * Resident #181 was not sufficiently groomed and appeared dirty for her medical appointment. * Medication was not filled on the day of her surgery. * Staff were not rinsing off the feces from her soiled clothes and mixed the soiled clothes with other dirty clothes to be sent home with her family. <p>The Grievance report documented staff were assisting in the dining room and were not aware of Resident #181's appointment, and her medication was ordered but did not arrive. The Grievance report documented staff were unable to determine who was not cleaning off the feces on Resident #181's clothes before sending them home to her family.</p>	F 585	<p>sustained will not recur.</p> <p>-Administrator or designee will conduct an audit on all grievances x3 months to ensure grievances are being carried out per facility policy and the proper party has been notified. Results will be brought to the monthly QAPI meeting with any identified negative trends addressed through system modification and staff education as appropriate.</p>		

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F 585	Continued From page 17 The Grievance report documented staff were educated about ensuring residents appeared appropriate for medical appointments, and not to send Resident #181's clothes before removing the feces. The Grievance report did not include documentation Resident #181's family representative was notified of the resolution of their grievance or was provided a report of the facility's investigative findings. On 3/26/19 at 8:26 AM, Resident #181's family representative said she completed two grievance forms in the facility. Resident #181's family representative said she did not receive a response or follow-up from the facility. On 3/28/19 at 9:28 AM, LPN #2 said she did an in-service with the staff regarding Resident #181's grievances and submitted it to the Staff Development Coordinator. LPN #2 said she going to look for the copy of the in-services and then provide a copy. On 3/29/19 at 10:28 AM, the DON said she did not know what medication was not ordered for Resident #181, and she was unable to find documentation of the in-services done with the staff. The DON said if she was the one assigned to investigate a grievance, she notified the resident or person who filed the grievance of her findings On 3/29/19 at 10:48 AM, the Administrator said all grievances were submitted to the Grievance Officer and were reviewed during their morning	F 585			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 585	Continued From page 18 stand-up meeting. The Administrator said the grievances were distributed to different departments based on the type of grievance. The Administrator said the person responsible for investigating the grievance should inform the resident or their representative of their investigative findings or how the complaint was addressed. The Administrator then reviewed Resident #181's Grievance form and said Resident #181's family representative was not notified of the investigation.	F 585			
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		4/30/19	

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F 623	<p>Continued From page 19</p> <p>before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with</p>	F 623			

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F 623	<p>Continued From page 20</p> <p>developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure transfer notices were provided in writing to residents. This was true for 1 of 3 residents (Resident #70) reviewed for transfer to a hospital. This failure had the potential for harm if residents were not made aware of or able to exercise their</p>	F 623	<p>F623</p> <p>1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p>		

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F 623	<p>Continued From page 21</p> <p>rights related to transfers. Findings include:</p> <p>Resident #70 was readmitted to the facility on 3/5/19, with multiple diagnoses including heart failure, hypertension (high blood pressure), pneumonia, and sepsis (severe infection).</p> <p>Resident #70's Discharge MDS assessment, dated 2/27/19, documented he had an unplanned discharge to the hospital.</p> <p>Resident #70's record documented he was hospitalized from 2/27/19 to 3/5/19 for pneumonia. There was no documentation Resident #70 or his representative were provided a written notice of transfer and the reason for the transfer.</p> <p>On 3/28/19 at 3:29 PM, the Administrator said the facility had not been informing residents in writing upon transfer to the hospital. The Administrator said the facility had not issued a notification of the transfer to Resident #70 or his representative. He said generally the facility had a discussion with the resident or their representative about the transfer.</p>	F 623	<p>--Resident #70 has discharged from the facility. Unable to correct the deficiency for this resident.</p> <p>2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>- All residents who transfer/discharge are at risk for being affected by the deficient practice.</p> <p>3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.</p> <p>-A notice of transfer/discharge form has been created and implemented to notify residents and/or their responsible party of transfer/discharge in writing and in a language and manner they understand per the CFR(s) 483.15(c)(3)-(6)(8). Facility will follow the timing of the notice as defined in CFR 483.15 (c)(4), except as specified in paragraphs (c)(4)(ii) and (c)(8). In the event that a resident transfers to the hospital for urgent medical needs such as resident #70 the facility will provide the notice as soon as practicable.</p> <p>In-service was given to SSW and Licensed Nurses on the "Notice of Proposed Discharge/Transfer" form.</p> <p>4.) Indicate how the corrective action(s)</p>		

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F 623	Continued From page 22	F 623	will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur.		
F 625 SS=D	<p>Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)</p> <p>§483.15(d) Notice of bed-hold policy and return-</p> <p>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-</p> <p>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing</p>	F 625	-Administrator or Designee will conduct an audit on all Transfers from the facility x3 months and brought to the monthly QAPI meeting with any identified negative trends addressed through system modification and staff education as appropriate.	4/30/19	

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F 625	<p>Continued From page 23</p> <p>facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident and staff interview, policy review, and record review, it was determined the facility failed to ensure a bed-hold notice was provided to a resident and/or their representative upon transfer to the hospital. This was true for 3 of 3 residents (#20, #70 and #83) reviewed for transfers to the hospital. This deficient practice created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time and may cause psychosocial distress if not informed they may be charged to reserve their bed/room. Findings include</p> <p>The facility's policy for Bed-Holds and Returns, dated 2018, documented residents or resident representatives were informed in writing of the bed-hold and return policy. Residents were permitted to return to an available bed in the location of the facility where he or she previously resided. If there was not an available bed in that part of the facility, the resident would be given the option to take an available bed in another distinct part of the facility and return to the previous distinct part when a bed became available.</p> <p>1. Resident #70 was admitted to the facility on 2/23/18, with multiple diagnoses which included heart failure and COPD.</p> <p>An annual MDS assessment, dated 12/3/18, documented Resident #70 was cognitively intact.</p>	F 625	<p>F625</p> <p>1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>-Admissions coordinator has been in-serviced of the bed hold policy and will be included in the admissions packet for all new admissions. Facility unable to fix the deficient practice for resident #20, #70, and #83.</p> <p>2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>- Other residents residing in the facility who are transferred to an acute setting which leads to temporary admission, resident will be provided written notification of bed hold and return policy.</p> <p>3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.</p> <p>-Resident and/or resident's responsible party to be provided state/facility bed hold</p>		

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F 625	Continued From page 24 Resident #70's record documented he was transferred to the hospital on 2/27/19 and returned to the facility on 3/5/19. There was no documentation in Resident #70's record a three-day bed-hold notice was provided to him or to his representative prior to his transfer to the hospital. On 3/28/19 at 3:29 PM, the Administrator said the facility did not issue a bed-hold notification to Resident #70 when he was transferred to the hospital. 2. Resident #83 was admitted to the facility on 12/8/18, with multiple diagnoses which included neurogenic bladder (dysfunction of the urinary bladder due to neurological damage). Resident #83's record documented he was transferred to the hospital on 2/2/19. There was no documentation in Resident #83's record a three-day bed-hold notice was provided to him or his representative prior to his transfer to the hospital. On 3/28/19 at 3:29 PM, the Administrator said the state of Idaho did not require a 3 day bed hold notice to be given, and the facility had not been providing notification to any resident who had been transferred out of the facility. The Administrator said the facility did not issue a bed-hold notification to Resident #83 when he was transferred to the hospital. 3. Resident #20 was admitted to the facility on 8/23/17, with multiple diagnoses which included major depressive disorder and neurogenic	F 625	policy at the time of transfer from the facility. In-service was given to the admissions coordinator that Bed hold policy will be implemented in the facility admission packet. In-service was given to SSW and Licensed nurses related to our policy of notifying residents and/or responsible parties of written documentation prior to discharge or within 24 hours. 4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur. -Administrator or Designee will audit for the bed hold notification being provided to resident and/or responsible party for every transfer x 3 months or more if needed, and results will be brought to the monthly QAPI with any identified negative trends addressed through system modification and staff education as appropriate.		

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F 625	Continued From page 25 bladder. A Nurse's Note, dated 12/27/18 at 9:50 AM, documented Resident #20 had difficulty breathing and was transferred to the hospital for evaluation. Resident #20's record did not include documentation a bed-hold notification was provided to her or her representative when she was transferred to the hospital. On 3/28/19 at 3:35 PM, the Administrator said the facility did not issue a bed hold notification to Resident #20. The Administrator then provided a copy of page 5 of the Idaho Medicaid Provider Handbook which documented "Bed holds are not reimbursed for hospitalization." "When a Long Term Care patient resident in the Nursing facility goes on Leave of Absence (LOA), the facility may be eligible for a reserve bed payment if the facility charges private paying patients for reserve bed days...Eligibility for reserve bed payment is determined by Medicaid for participants." The Administrator said they had not issued bed hold notification to their residents.	F 625			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and resident, family, and staff interviews, the facility failed to ensure the MDS assessment accurately reflected a resident's hospice status. This was true for 1 of 19 residents (Resident #52) whose MDS assessments were reviewed for accuracy. This	F 641	F641 1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	4/30/19	

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F 641	<p>Continued From page 26</p> <p>failure created the potential for harm should residents receive inappropriate care related to inaccurate MDS assessments. Findings include:</p> <p>Resident #52 was readmitted to the facility on 2/13/18, with multiple diagnoses including hypertension (high blood pressure) and dementia.</p> <p>Resident #52's annual MDS assessment, dated 2/21/19, did not document she was receiving hospice services.</p> <p>Resident #52's care plan documented coordination with hospice.</p> <p>Resident #52's Progress Notes included documentation of each hospice visit and communication with the facility.</p> <p>On 3/26/19 at 11:40 AM, Resident #52 said she was not receiving hospice services. Her daughter said she was receiving hospice services.</p> <p>On 3/27/19 at 9:32 AM, the MDS Coordinator said there was an error in Resident #52's MDS coding and she was indeed receiving hospice services.</p>	F 641	<p>-On 3/27/19, when the surveyor identified that the facility had inadvertently not selected <input type="checkbox"/> Yes <input type="checkbox"/> on resident #52 Annual MDS Section O. Special Treatments, Procedures, Programs 0100.K regarding Hospice the facility Resident Assessment Coordinator (RAC) completed a modification of the 2/21/19 Annual MDS Question O0100.K per RAI manual directions. Question O0100.K was checked <input type="checkbox"/> Yes <input type="checkbox"/> to indicate Hospice and the MDS correction was transmitted RAI guidelines. The modified MDS was accepted. The surveyor was given a copy of the corrected MDS on 3/27/19.</p> <p>2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>-All residents currently receiving a hospice benefit were audited by the RAC to ensure that the MDS section O was coded correctly to reflect the hospice services. This audit was completed 4/17/19.</p> <p>3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.</p> <p>-VVNR has implemented the Point Click Care (PCC) Analytics Compliance Package effective 4/18/19. This package audits all MDS <input type="checkbox"/> and verifies accuracy and identifies inconsistencies on the MDS</p>		

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F 641	Continued From page 27	F 641	<p>as compared to prior MDSs that have been completed for the same resident. Additionally, the package identifies coding on the MDS that conflict with one another. Each MDS completed is automatically ran through this analytics compliance package before the MDS can be locked and then transmitted.</p> <p>4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur.</p> <p>-Beginning the week of 4/22/19 RAC or designee will run an MDS verification report on 2 residents and audit to ensure proper MDS coding. The MDS verification report will be generated for two random residents- every week x 4 weeks, then every two weeks x 2 and then monthly. Results of the MDS audits will be presented in the facility QAPI meeting for three months (or longer as necessary) beginning in May with any identified negative trends addressed through system modification and staff education as appropriate.</p>		
F 656 SS=E	<p>Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)</p> <p>§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable</p>	F 656		4/30/19	

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

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F 656	Continued From page 28 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and resident and staff interview, it was determined the	F 656	1.) What corrective action(s) will be accomplished for those residents found to		

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F 656	<p>Continued From page 29</p> <p>facility failed to ensure residents' code status was on their care plan. This was true for 4 of 19 residents (Resident #36, #49, #73, and #232) whose care plans were reviewed. This failure created the potential for harm should residents receive inappropriate care due to missing information on their care plan. Findings include:</p> <p>The facility's policy for Care Plans, dated 2018, documented the following:</p> <ul style="list-style-type: none"> * The IDT, with the resident and their family or legal representative, developed and implemented a comprehensive, person-centered care plan for each resident. * The care planning process included the resident's personal and cultural preferences in developing their goals of care. * Described services were provided to achieve or maintain the resident's highest practicable physical, mental, and psychosocial well-being. * Described services that would otherwise be provided, but were not provided due to the resident exercising their rights, including the right to refuse treatment. * The care plan reflected the resident's wishes regarding care and treatment goals. <p>1. The facility's policy for Advance Directives, dated 2018, documented the care plan team was informed of any changes or revocations to the Advanced Directive, in order for appropriate revisions to be made in the MDS assessment and care plan.</p>	F 656	<p>have been affected by the deficient practice.</p> <p>Resident #36, # 49, and #232; comprehensive care plan has been updated to include code status</p> <p>Resident #73 has discharged the facility, unable to correct deficiency for this resident</p> <p>2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>All new admissions will have an advanced directive care plan added to their comprehensive care plan with a review during welcome conference; existing residents comprehensive care plans will be reviewed during quarterly care conference.</p> <p>Social Service Workers in-serviced to ensure that comprehensive care planning is understood and implemented according to CMS guidelines, including the implementation of Advanced Directive and POST status Care Plan.</p> <p>3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.</p> <p>Social Services will audit to ensure that all</p>		

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F 656	Continued From page 30 Residents' care plans did not include documentation of their code status (or end of life wishes). Examples include: a. Resident #36 was admitted to the facility on 4/16/18, with multiple diagnoses including Alzheimer's disease and COPD (progressive lung disease that results in shortness of breath). Resident #36's quarterly MDS assessment, dated 1/24/19, documented he had severe cognitive impairment. Resident #36's physician orders documented DNR was ordered on 4/17/18. Resident #36's POST documented he was DNR with comfort measures only. The POST was signed by Resident #36's guardian on 4/17/18. Resident #36's care plan did not document he was DNR. On 3/29/19 at 10:17 AM, the DON said she did not see Resident #36's code status on his care plan. b. Resident #49 was admitted to the facility on 1/11/19, with multiple diagnoses including sepsis (severe infection), acute embolism and thrombosis (blood clot) of the right lower extremity, heart block (abnormal heart rhythm where the heart beats too slow), and a cardiac pacemaker. Resident #49's POST documented DNR with comfort measures only. The POST was signed	F 656	residents comprehensive care plans complete and accurate. Social Services will review Advanced Directive Care Plan during all care conferences, cape plans will be updated according to resident wishes and their POST status. 4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur. Social Services Workers will audit comprehensive care plan and complete an Advanced Directive and POST status Care Plan and update as needed. Audit will be completed monthly for 6 months until no longer deemed need by the facility QAPI team.		

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F 656	<p>Continued From page 31 by Resident #49's son on 1/11/19.</p> <p>Resident #49's physician orders documented DNR, was dated 2/13/19.</p> <p>On 3/25/19 at 10:24 AM, Resident #49's DNR status was not documented on her care plan.</p> <p>On 3/29/19 at 9:58 AM, the DON said the code status was added to Resident #49's care plan on 3/26/19, and it was not on the care plan before that time.</p> <p>c. Resident #73 was admitted to the facility on 2/27/19, with multiple diagnoses including sepsis, acute respiratory failure with hypoxia (low oxygen level in the blood), and atrial fibrillation (irregular heart rhythm).</p> <p>Resident #73's admission MDS assessment, dated 3/6/19, documented she was cognitively intact.</p> <p>Resident #73's physician orders documented DNR was ordered on 2/28/19.</p> <p>Resident #73's POST documented she was DNR with comfort measures only.</p> <p>Resident #73's care plan did not document her DNR status.</p> <p>On 3/29/19 at 10:05 AM, the DON said she did not see Resident #73's code status on her care plan.</p> <p>d. Resident #232 was admitted to the facility on 3/13/19, with multiple diagnoses including atrial</p>	F 656			

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F 656	Continued From page 32 fibrillation, hemiplegia and hemiparesis (weakness and paralysis on one side of the body) following a stroke, and chronic kidney disease. Resident #232's physician orders documented DNR was ordered on 3/14/19. Resident #232's POST documented DNR with comfort measures only. Resident #232's care plan did not document her code status. On 3/29/19 at 10:09 AM, the DON said she did not see Resident #232's code status on the care plan. On 3/28/19 at 8:50 AM, the DON said Resident #37's wrist splint was part of the RNA program. On 3/28/19 at 8:53 AM, LPN #4 said Resident #37's wrist brace was not on and the RNA did that.	F 656			
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		4/30/19	

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F 657	<p>Continued From page 33</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and family and staff interview, it was determined the facility failed to ensure residents' care plans were revised and updated as residents' needs changed, and failed to ensure initial care plan conferences occurred. This was true for 3 of 19 residents (Resident #31, #37 and #181) whose care plans were reviewed. This had the potential for harm if cares and/or services were not provided due to incorrect information and if residents were not given the opportunity to participate in their plan of care. Findings include:</p> <p>The facility's policy for Care Plans, dated 2018, documented the following:</p> <p>* Described services were provided to achieve or</p>	F 657	<p>F657</p> <p>1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>-Resident #181 has discharged from the facility. Unable to correct the deficiency for this resident.</p> <p>Resident # 37 comprehensive care plan has been updated to reflect that she has a fracture of the right femoral neck.</p> <p>Resident #31 continues to reside at Valley View. Facility is unable to correct the</p>		

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F 657	<p>Continued From page 34</p> <p>maintain the resident's highest practicable physical, mental, and psychosocial well-being.</p> <p>* Each resident's comprehensive person-centered care plan was consistent with their right to participate in developing and implementing their care plan.</p> <p>* Residents were informed of their right to participate in their treatment.</p> <p>* The care planning process facilitated involvement of the resident and/or their representative.</p> <p>* Residents' care plans were revised as their information and conditions changed.</p> <p>1. Resident #181 was readmitted to the facility on 9/11/17, with multiple diagnoses including multi-system degeneration of the autonomic nervous system (a neurological disorder affecting the body's involuntary functions, including blood pressure, bladder function and muscle control).</p> <p>Resident #181's quarterly MDS assessment, dated 6/6/18, documented she was cognitively intact.</p> <p>a. A care plan, dated 9/11/17, documented Resident #181 had an Activities of Daily Living (ADL) self-care performance deficit related to deconditioning and weakness due to multisystem atrophy (a rare degenerative disorder of the nervous system). The care plan documented Resident #181 required extensive assistance of one staff member for her ADLs.</p>	F 657	<p>missing care plan conference. This resident admitted initially as a five day hospice respite and then decided to remain as a LTC resident. Facility completed a care conference with resident and his family/responsible party.</p> <p>2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. -All residents on hospice are at risk for discrepancy between the facility and hospice plans of care. Facility will audit all hospice patients plan of care for discrepancies and resolve any identified issues.</p> <p>Social Services will audit to ensure that all residents are current and receiving initial care plan and quarterly care plan conferences.</p> <p>3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.</p> <p>-Nursing Staff, Social Services, Activities, Dietary, Housekeeping, Maintenance and therapy in-serviced by DON or designee on facility care plan process and the expectation that a resident and/family request be communicated to the IDT. Identified resident &/or family preference/request will be documented on the 24-hour report. The staff member writing the request on the 24 hour report</p>		

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F 657	<p>Continued From page 35</p> <p>A hospice record, documented a care conference was held on 6/14/18 and attended by Resident #181's family representative, the Activity Director, the Dietitian, and the SW. During the care conference, Resident #181's family representative voiced concern Resident #181 was a one person assist. The family felt she needed two staff members to assist her, and they were worried someone was going to get hurt.</p> <p>Resident #181's IDT Care Plan Conference/ Welcome Meeting, dated 6/14/18, did not include documentation of the concerns her family representative expressed regarding Resident #181 having one staff member assisting her with ADLs.</p> <p>On 3/26/19 at 8:26 AM, Resident #181's family representative said during a care conference she requested to have two people assist Resident #181 with ADLs.</p> <p>On 3/28/19 at 1:25 PM, the DON said she was not aware Resident #181's family representative had a concern with her being assisted by one staff member. The DON said Resident #181 was "tiny" and she was able to pivot transfer with the help of one staff member. The DON said if a resident or family representative requested a two-person assist for a resident, the facility accommodated the request and added it to the care plan.</p> <p>On 3/29/19 at 11:10 AM, the Activity Director said she did not remember what was discussed during Resident #181's care conference on 6/14/18. The Activity Director said the SW documented the concerns/requests during the</p>	F 657	<p>will also communicate to the appropriate department manager or unit manager the specific request/preference. The 24-hour report is reviewed at daily stand up IDT meeting. The IDT will ensure that the request/preference has been followed up on and the care plan has been updated as appropriate.</p> <p>Social Services will coordinate resident care conferences for new and current residents to ensure that initial and quarterly care conferences are scheduled and invite resident/family to attend. Social Services will complete the Care Conference in the Evaluation tab of Point Click Care (PCC) for all care conferences.</p> <p>When a hospice resident is scheduled for a Care Conference, Social Services will invite hospice representative to attend the conference. Hospice and Facility plans of care will be reviewed to ensure that there are no discrepancies. Any discrepancies identified will be resolved as appropriate and respective plans of care will be updated.</p> <p>4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur.</p> <p>-Administrator or designee will audit the 24-hour report to ensure that all communicated resident preferences/requests were followed up by the appropriate department and care plan</p>		

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F 657	<p>Continued From page 36 meeting.</p> <p>The SW progress notes did not include documentation of the care conference held on 6/14/18.</p> <p>b. A Nurse's Note, dated 5/20/18 at 5:06 PM, documented Resident #181's family representative was concerned her chest area was sticky due to her oral secretions, and they brought in a bib to prevent her secretions from soiling her chest area.</p> <p>Resident #181's care plan did not include the use of a bib to prevent her oral secretions from soiling her chest area.</p> <p>On 3/28/19 at 1:25 PM, the DON said when Resident #181's family representative requested for her to wear a bib it should have been added to her care plan. The DON said Resident #181's care plan was not updated when her family requested for her to wear a bib.</p> <p>c. Resident #181's Hospice Recertification Plan of Care (POC) order, dated 5/23/18 to 7/21/18, documented she could not use a walker due to contractures of her hands and arms, and she had a wheelchair for daily use.</p> <p>Resident #181's care plan, revised on 5/31/18, documented she required extensive assistance of one staff member, a gait belt, and a front wheel walker (FWW) for ambulation.</p> <p>On 3/28/19 at 1:25 PM, the DON said she remembered Resident #181 walking with her FWW and being assisted by one staff member.</p>	F 657	<p>updated as needed. Audit will be done 2 x weekly x 4 weeks, then 2 x biweekly x 2, then monthly until no longer deemed need by the facility QAPI team.</p> <p>Administrator or designee will audit resident charts for the Care Conference evaluation to ensure that all newly admitted or readmitted residents have received an initial care conference. Additionally, will audit 2 residents using the MDS Annual/Quarterly schedule to ensure that Care Conference evaluation has been completed and that any identified resident preferences/requests were documented on the 24-hour report and that the appropriate IDT member followed up and updated the care plan as appropriate. Audit will be done weekly x 4 weeks, then biweekly x 2, then monthly until no longer deemed need by the facility QAPI team.</p> <p>DON or designee will audit care plan of 2 residents receiving hospice services to ensure that there are no discrepancies between the facility and hospice plans of care. Audit to be completed weekly x 4; then biweekly x 2; then monthly until no longer deemed needed by the facility QAPI team.</p> <p>Results of the 24-hour report and care plan audits will be presented in the facility QAPI meeting for three months (or longer as necessary) beginning in May, with any identified negative trends addressed through system modification and staff</p>		

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F 657	Continued From page 37 On 3/29/19 at 10:28 AM, the DON provided a hospice visit report, dated 8/7/17, which documented Resident #181 ambulated using her walker, and she was assisted by one staff member. The DON said Resident #181's care plan should have been updated. 2. Resident #37 was readmitted to the facility on 7/28/18, with multiple diagnoses including multiple sclerosis (a potentially disabling disease of the brain and spinal cord), hemiplegia (paralysis on one side of the body), and dementia. Resident #37's quarterly MDS assessment, dated 1/31/19, documented she was cognitively intact. A right hip x-ray report, dated 1/11/19, documented Resident #37 had an acute fracture of the femoral neck (part of the hip joint). A Progress Note, dated 1/25/19 at 3:09 PM, documented Resident #37's daughter was contacted regarding the right femur fracture, and an investigation was in progress. A Progress Note, dated 2/11/19 at 5:56 PM, documented a meeting was held with Resident #37's daughter and granddaughter. The plan was discussed regarding Resident #37's hip fracture, and an x-ray was planned in 4 to 6 weeks from that day. A Progress Note, dated 3/11/19 at 1:16 PM, documented an x-ray was done of Resident #37's right hip and there were no significant changes.	F 657	education as appropriate.		

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F 657	<p>Continued From page 38</p> <p>On 3/27/19 at 2:56 PM, the DON said Resident #37's hip fracture was not documented on her current care plan in the electronic medical record. The DON said prior to January 2019, the care plans were in a different system under a different management system, she would look to see if there was information on the previous care plan regarding Resident #37's hip fracture, and there was no documentation in her current record that identified her hip fracture on the care plan.</p> <p>On 3/28/19 at 8:00 AM, the facility provided a copy of a Temporary Care Plan for Resident #37, which was on paper. The hip fracture care plan was initiated on 1/14/19, and it documented she had a fracture of the right femoral neck. Interventions included repositioning 2 to 3 times each shift, providing pain management via pharmaceutical and non-pharmaceutical interventions as ordered and per the plan of care, and follow up x-ray as ordered. The Temporary Care Plan was not found in Resident #37's current electronic medical record.</p> <p>On 3/29/19 at 9:51 AM, the DON said Resident #37's hip fracture did not change her care, and her care was documented on the care plan. The DON said there was nothing on Resident #37's care plan that documented she had a hip fracture, but her care plan directed her care that would address the fracture.</p> <p>3. Resident #31 was admitted to the facility on 1/16/19, with multiple diagnoses including COPD.</p> <p>An admission MDS assessment, dated 1/16/19,</p>	F 657			

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F 657	Continued From page 39 documented he was moderately cognitively intact. Documentation of a care plan conference with Resident #31 or his representative was not found in his record. On 3/29/19 at 10:08 AM, the Medical Record Director said she was unable to find Resident #31's IDT Care Plan Conference/Welcome Meeting Form. On 3/29/19 at 10:23 AM, the DON said she did not find Resident #31's IDT Care Plan Conference/Welcome Meeting Form.	F 657			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced	F 688		4/30/19	

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F 688	<p>Continued From page 40</p> <p>by: Based on observation, staff interview, record review and policy review it was determined that the facility failed to implement the a care plan related to contracture and application of a splint for 1 of 1 (Resident #30) reviewed for contractures. This failure created the potential for harm should Resident #30 experience a decline in their range of motion due to not receiving care as planned. Findings include:</p> <p>The facility's policy for Resident Mobility and Range of Motion, dated 2018, documented the following:</p> <ul style="list-style-type: none"> * Residents with impaired mobility received treatment and services to improve and/or prevent further decline in range of motion. * The IDT developed the care plan based on the comprehensive assessment, and revised the care plan as needed. * The care plan may contain specific interventions, exercises, and therapy to maintain, prevent avoidable decline, and/or improve mobility and range of motion. <p>Resident #37 was readmitted to the facility on 7/28/18, with multiple diagnoses including multiple sclerosis (a disabling disease of the brain and spinal cord), hemiplegia (paralysis on one side of the body), and dementia.</p> <p>Resident #37's quarterly MDS assessment, dated 1/31/19, documented she was cognitively intact and received a Restorative Nursing Program, including splint or brace assistance, on 1 of the</p>	F 688	<p>F688</p> <p>1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>-Resident #37 has been referred to OT to be evaluated for a new splint, as her previous splint was no longer functional. OT continues at this time to follow resident #37. At such time OT discontinues resident from services than the residents don/doff splint schedule will be managed by the licensed nurse and recorded on the TAR to ensure that the splint used per the plan of care.</p> <p>2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;</p> <p>All residents receiving RNA program and residents who have a splint are at risk for the deficient practice. All residents receiving RNA program and residents who have a splint will be reviewed. All splint management will be changed to licensed nurse responsibility and recorded on the TAR to ensure that the splint is used per the plan of care.</p> <p>3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.</p>		

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F 688	Continued From page 41 past 7 calendar days. Resident #37's care plan, initiated on 6/22/16 and revised on 11/13/17, documented she had impaired physical mobility related to end stage multiple sclerosis. Interventions included a Restorative Splint/Brace Program as follows: Wash the left hand with warm water and thoroughly dry, massage palm gently, and apply the left resting hand splint during the day. Licensed nurse to ensure the splint is placed appropriately. The interventions were initiated on 2/9/18 and revised on 1/18/19. On 3/25/19 at 10:08 AM, Resident #37 was lying in bed. Her left wrist appeared contracted. The splint was not in place to her left arm. Resident #37 said staff did some exercises but she was not sure what they did. On 3/27/19 at 3:36 PM, CNA #2 said the Restorative Nurse Aide (RNA) was to massage Resident #37's left hand and apply the splint. CNA #2 said Resident #37 did not wear the splint during meals. On 3/27/19 at 3:44 PM, Resident #37 was in her room sitting in her wheelchair, and the splint was not on her left arm. Resident #37 said staff did not apply the brace that day. On 3/28/19 at 8:31 AM, Resident #37 was in her room sitting up in her wheelchair and the splint was not on her left arm.	F 688	Nursing staff have been educated by DON or designee on or before 4/30/19 regarding the requirements to provide RNA programs, how to manage a resident with a splint and how to identify issues/concerns related to RNA programs. 4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur. Beginning the week of 5/1/19 DON or designee will complete audit to ensure compliance with splint management and restorative programs. Audit will be done on 3 residents weekly for 4 weeks, then 2 residents weekly for 8 weeks. Identified concerns will be corrected at the time identified, as possible & referred to DON for resolution. Results of the audits will be presented in the facility QAPI meeting for three months (or longer as necessary) beginning in June, with any identified negative trends addressed through system modification and staff education as appropriate.		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		4/30/19	

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F 695	<p>Continued From page 42</p> <p>tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure staff changed resident's oxygen tubing per physician orders and stored it properly. This was true for 3 of 5 residents (Residents #20, #31, and #70) reviewed for oxygen therapy. This failure created the potential for harm from respiratory infections due to the growth of pathogens (organisms that cause illness) in oxygen tubing. Findings include:</p> <p>The facility's undated Oxygen Administration policy directed staff to verify and review the physician's order for oxygen administration, review the resident's care plan to assess for any special needs, and assemble the equipment and supplies as needed.</p> <p>1. Resident #70 was admitted to the facility on 2/23/18, with multiple diagnoses which included heart failure and COPD.</p> <p>An annual MDS assessment, dated 12/3/18, documented Resident #70 was cognitively intact and received oxygen therapy.</p> <p>Resident #70's March 2019 Medication Administration Record (MAR) documented his</p>	F 695	<p>1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident # 70 had their oxygen tubing changed on 4/15/19, both the concentrator and portable oxygen tubing has been labeled with the date it was changed. Resident has a bag for both sets of tubing to be stored when not in use. Nebulizer tubing was changed 4/1/19 and has appropriate label and a bag for storage of the tubing when not in use. This resident can remove his own oxygen tubing and leave his room independently. He will be encouraged to place his tubing in the storage bag provided. Staff educated to monitor his room when giving cares for appropriate tubing labeling and storage.</p> <p>Resident #20 had their oxygen tubing changed on 4/15/19, both the concentrator and portable oxygen tubing has been labeled with the date it was changed. Resident has a bag for both sets of tubing to be stored when not in</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/29/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1140 NORTH ALLUMBAUGH STREET BOISE, ID 83704		
(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 695	<p>Continued From page 43 oxygen tubing was changed on 3/15/19.</p> <p>On 3/28/19 at 9:56 AM, the following respiratory equipment was observed without a date or label in Resident #70's room:</p> <ul style="list-style-type: none"> * Oxygen tubing connected to the oxygen concentrator * Oxygen tubing connected to a face mask that was wound in the bed rail * A nasal cannula and tubing rolled up and laying in the window sill * A nebulizer tubing and T-apparatus (an inhalation delivery device) that was on top of a bedside table to the left * Continuous Positive Airway Pressure (CPAP) tubing that was on a bedside table to the right * The CPAP mask was in two parts, one part was on the right bedside table and the other part was on the overbed table. <p>On 3/28/19 at 9:56 AM, LPN #1 said the oxygen tubing must have been changed the day before. LPN #1 said the oxygen tubing, face masks, and apparatus should have been labeled and dated when they were changed, and they should be stored inside a plastic bag when not in use. LPN #1 said the T-apparatus should be stored on the back of the nebulizer, but it was difficult to get it to stay there and it often fell out of the holder.</p> <p>On 3/28/19 at 1:40 PM, the DON said she expected the staff to label and date oxygen</p>	F 695	<p>use. All unlabeled tubing was removed from the room.</p> <p>Resident #31 had their oxygen tubing changed on 4/16/19, both the concentrator and portable oxygen tubing has been labeled with the date it was changed. Resident has a bag for both sets of tubing to be stored when not in use. Residents order for changing Oxygen tubing was reviewed with his hospice physician and order was changed to be changed monthly on the 15th of each month.</p> <p>2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;</p> <p>All residents who utilize respiratory equipment (oxygen, nebulizer, BiPap/CPap) are at risk for this deficient practice and have been audited to ensure that oxygen and nebulizer tubing has been changed per the MD order and has been labeled with the date of the change and that all respiratory equipment has a bag so that it can be stored properly when not in use.</p> <p>3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.</p> <p>Nursing staff have been in-serviced on the management of respiratory</p>		

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F 695	<p>Continued From page 44</p> <p>tubing and other respiratory equipment when they were changed, and store them in a plastic bag when not in use. The DON said the facility did not have a policy for changing and labeling oxygen tubing and other equipment.</p> <p>On 3/28/19 at 2:04 PM, the DON said if the facility did not have a policy to guide nursing practices, the facility referred to The Lippincott Manual of Nursing Practice for the standard of practice.</p> <p>2. Resident #20 was admitted to the facility on 8/23/17, with multiple diagnoses including heart disease.</p> <p>A quarterly MDS assessment, dated 12/9/18, documented she was cognitively intact and received oxygen therapy.</p> <p>Resident #20's March 2019 physician's orders directed night shift staff to change her oxygen tubing on the 15th of each month.</p> <p>Resident #20's March 2019 Treatment Administration Record (TAR) documented her oxygen tubing was changed on 3/15/19.</p> <p>On 3/25/19 at 10:46 AM, 3/26/19 at 9:16 AM, and on 3/27/19 at 8:58 AM, Resident #20 was observed in bed receiving oxygen therapy via a nasal cannula at 2 liters per minute (LPM). There was a plastic bag hanging on the oxygen concentrator which contained several oxygen tubings. The plastic bag was not dated.</p> <p>On 3/27/19 at 10:03 AM, LPN #3 said Resident #20's oxygen tubing was changed once a month</p>	F 695	<p>equipment, including the changing out, labeling and storage of the equipment when not in use.</p> <p>4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur.</p> <p>Beginning the week of 5/1/19 ED or designee(s) will complete Grand Rounds. Residents who utilize oxygen will be audited to ensure that the tubing is labeled with the date it was changed, that the date is no more than 30 days prior, and that the tubing/equipment is being stored appropriately when not in use. Audit will be done 3 days per week x 2 weeks, then no less than 2 x weekly. Identified concerns will be corrected at the time identified, as possible & referred to DON for resolution.</p> <p>DON or designee will conduct an audit the week of 5/1/19 of residents that receive nebulizer treatments to ensure all nebulizer tubing was changed out, labeled and stored properly.</p> <p>DON or designee will conduct an audit the week of 5/16/19 of all residents that use oxygen to ensure that oxygen tubing was changed out and labeled.</p> <p>In the months of June and July 2019, DON or designee will audit 10 residents who utilize either nebulizer or oxygen equipment to ensure that the appropriate tubing was changed out per MD order, labeled and stored appropriately. Monthly</p>		

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F 695	<p>Continued From page 45</p> <p>by the night shift nurse. LPN #2 checked the plastic bag and said it should be dated. LPN #2 also said the oxygen tubing should be thrown away and not stacked inside the plastic bag.</p> <p>On 3/27/19 at 2:52 PM, the DON said the facility did not have a policy for changing and labeling oxygen tubing, and the facility followed the physician's orders for oxygen. The DON said she expected the staff to follow the standard of practice as per Lippincott Manual of Nursing Practice (a nursing reference book), that all oxygen tubing should be dated, labeled, and stored in plastic bags when not in use.</p> <p>3. Resident #31 was admitted to the facility on 1/16/19, with multiple diagnoses including COPD.</p> <p>An admission MDS assessment, dated 1/16/19, documented Resident #31 was moderately cognitively impaired and received oxygen therapy.</p> <p>Resident #31's physician orders, dated 1/17/19, included an order to change oxygen tubing weekly and PRN (as needed) one time a day every Tuesday and Sunday.</p> <p>Resident #31's February and March 2019 TARs, documented the oxygen tubing was changed on 2/3/19, 2/5/19, 2/10/19, 2/12/19, 2/15/19, 2/17/19, 2/19/19, 2/24/19, 2/26/19, 3/3/19, 3/5/19, 3/10/19, 3/12/19, 3/17/19, 3/19/19, 3/24/19 and 3/26/19.</p> <p>On 3/25/19 at 2:52 PM, Resident #31 was observed in his room receiving oxygen at 3 LPM. The oxygen tubing was not dated. A plastic bag was observed hanging on the wall, and it was</p>	F 695	<p>audits will continue until facility QAPI team identifies the issue has been satisfactorily resolved.</p> <p>Results of the audits will be presented in the facility QAPI meeting for three months (or longer as necessary) beginning in June, with any identified negative trends addressed through system modification and staff education as appropriate</p>		

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F 695	Continued From page 46 dated 2/19/19. On 3/27/19 at 10:03 AM, LPN #2 said Resident #31's oxygen tubing was changed once a month and PRN by the night shift nurse. LPN #2 checked the plastic bag, saw the date on it, and said it should have been changed. On 3/27/19 at 2:52 PM, the DON said the facility did not have a policy for changing and labeling oxygen tubing. The DON said the facility followed the physician's orders for oxygen. The DON said she expected the staff to follow the standard of practice as per the Lippincott Manual of Nursing Practice that all oxygen tubing should be dated, labeled, and stored in plastic bags when not in use.	F 695			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		4/30/19	

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F 812	<p>Continued From page 47</p> <p>serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, policy review, review of the FDA (Food and Drug Administration) Food Code, and staff interview, it was determined the facility failed to ensure food was prepared and served under sanitary conditions. This was true when six food service staff members were observed not having scalp and/or facial hair contained while preparing food. This failure had the potential to affect all residents who dined in the facility, and created the potential for harm from contaminated food. Findings include:</p> <p>The FDA Food Code, Section 2-402.11, dated 2017, directed food employees to wear restraints such as hats, hair covering or nets, beard restraints, and clothing that covers body hair, that effectively prevents hair from contacting exposed food.</p> <p>The facility's Dress Code policy, dated 8/1/14, documented hair should be kept clean and neatly arranged. Associates working in the kitchen must wear approved hair restraints.</p> <p>On 3/25/19 at 8:38 AM, kitchen staff members were observed not having hair contained within hair restraints or facial hair covered. Dietary Staff (DS) #3 was slicing pies in preparation for the noontime meal. She had long dark hair which was braided, but she was not wearing a hair net.</p> <p>On 3/25/19 at 9:00 AM, DS #4 was preparing food on a counter across from the stove and ovens. She was wearing a black cap, but her</p>	F 812	<p>1.)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Dietary staff are to be in-serviced by dietary manager or designee on requirement to wear a hairnet when in clean or food production area <input type="checkbox"/>s in the kitchen</p> <p>2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;</p> <p>-All residents who receive food from the kitchen were the deficient practice occurred are at risk for getting hair in their food</p> <p>3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.</p> <p>-In-services were given to all dietary staff immediately on ensuring that food was prepared and served under sanitary condition, including hair nets</p> <p>-Kitchen manager, or designee will</p>		

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F 812	<p>Continued From page 48</p> <p>ponytail was not contained within a hair restraint. DS #7, a server for the first-floor dining room, did not wear a hair restraint when she entered the kitchen to retrieve a food item, which she carried back toward the dining room after exiting the main kitchen. DS #5, a food preparation staff member, was observed just inside the dish room with a hair restraint, but a large lock of her hair, approximately two inches long, was not contained in her hair restraint.</p> <p>On 3/25/19 at 4:01 PM, DS #4 was observed in the food preparation area, working near the stove and at the counter just below the spices. DS #4 was covering containers of food with plastic wrap. She was wearing a black cap, but her ponytail was not contained in a hair net.</p> <p>On 3/27/19 at 10:50 AM, DS #6 was observed in the kitchen wearing a beard restraint, but his mustache and whiskers, estimated to be three-quarters to one inch in length, were not covered by the beard restraint.</p> <p>On 3/27/19 at 10:56 AM, DS #6 was observed walking in the kitchen near the pots and pans. He removed the beard restraint and it was hanging around his neck. As he approached the stove and counter/spice storage area, he positioned the beard restraint to cover his beard, but he did not cover his mustache.</p> <p>On 3/28/19 at 2:35 PM, DS #8 was observed washing dishes. She was wearing a hair restraint, but her bangs were not contained within the hair restraint.</p> <p>On 3/28/19 at 2:40 PM, DS #9 said when staff</p>	F 812	<p>monitor for the use of hairnets and beard nets. They will correct noncompliance if found to occur, And document on monitoring form.</p> <p>4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur. Kitchen Manager and CDM will meet weekly X 10 weeks and review staff compliance and corrective actions. After 10 weeks if there is no increasing trend of noncompliance managers will meet monthly.</p>		

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F 812	<p>Continued From page 49</p> <p>were working in the kitchen, they must ensure their hair was contained in a hair restraint because loose strands of hair could potentially fall into prepared food, onto clean dishes, or other pieces of kitchen equipment. He said staff with facial hair were instructed to wear beard and mustache covers to prevent their facial hair from falling into the food. He said it was unsanitary for hair to fall into the residents' food or onto equipment used to prepare the food.</p> <p>On 3/29/19 at 11:22 AM, DS #4 said she was not aware she was supposed to contain her ponytail with a hair restraint. She said she thought wearing a cap was enough, but now she knew to fully cover her hair to prevent physical contamination of the food and kitchen equipment.</p> <p>On 3/28/19 at 1:56 PM, the DON said she wanted the food served to the residents to be appetizing, because she wanted to prevent residents' weight loss. She said if a hair was found in a resident's food, a fresh plate of food was provided. The DON said she did not consider food with hair in it appetizing.</p> <p>On 3/28/19 at 2:25 PM, DS #2 said staff working in the kitchen must wear hair restraints. He said ponytails and facial hair must be contained by a hair restraint. He said he was working in the kitchen on 3/27/19, during preparation and plating of the lunch meal, but he did not notice there were kitchen staff members who did not have their scalp and facial hair fully contained. He said hair must be kept out of the residents' food. DS #2 said he wanted the residents to find the food appealing, and many residents looked forward to mealtime as a highlight of their day.</p>	F 812			

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F 812	Continued From page 50 DS #2 said he wanted to ensure residents ate their food, because nutritious meals helped them maintain their health and well-being. On 3/29/19 at 8:54 AM, the Certified Dietary Manager (CDM) stated kitchen staff involved in the preparation and serving of food should have their scalp and facial hair contained by using hair restraints and beard restraints. The CDM said facial hair, including mustaches, must be covered by a beard restraint. He said a pony tail should be tucked inside a cap or contained within a hair net. He said the goal was to prevent physical contamination of the food served to the residents.	F 812			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §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)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to	F 880		4/30/19	

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F 880	<p>Continued From page 51</p> <p>§483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and</p>	F 880			

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F 880	<p>Continued From page 52</p> <p>transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, record review, and staff interview, it was determined the facility failed to ensure appropriate hand hygiene was performed by staff during meal service and during wound care, and urinary catheter care was provided in a manner consistent with professional standards and infection prevention measures. This was true for 2 of 19 residents (Resident #55 and #232) observed for infection prevention practices. These failures created the potential for harm should residents experience infection from cross contamination due to lack of appropriate hand hygiene. Findings include:</p> <p>The Centers for Disease Control and Prevention (CDC) website, accessed on 4/2/19, documented hand hygiene should be performed after removing gloves.</p> <p>The facility's policy for Handwashing/Hand Hygiene, dated 2018, directed staff to perform hand hygiene using an alcohol based hand rub or soap and water before applying sterile gloves, before and after direct contact with residents, after handling used dressings or contaminated equipment, after contact with objects in the immediate location of the resident, before and after eating or handling food, before and after assisting a resident with meals, and after removing gloves.</p>	F 880	<p>F880</p> <p>1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Nursing staff were educated regarding infection control practices related to handwashing, during resident cares, wound care, when changing gloves, and assisting residents with food intake.</p> <p>Nursing staff were educated regarding proper procedure for completing urinary catheter care.</p> <p>CNA #4 received 1:1 education from the survey team member on 3/25/19 at 12:25 and acknowledged her mistake.</p> <p>CNA #3 received 1:1 education from the DON on 3/27/19 following the identification of improper catheter care.</p> <p>Wound Nurse interviewed 1:1 by DON and states that she performed hand washing upon entering the residents room, prior to removing the old dressing, prior to donning new gloves to apply the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/29/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1140 NORTH ALLUMBAUGH STREET BOISE, ID 83704		
(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 880	<p>Continued From page 53</p> <p>The facility's policy for Infection Prevention and Control Program, dated 11/2017, directed staff to perform hand hygiene after removing personal protective equipment and after contact with visibly contaminated surfaces or objects in the resident's room.</p> <p>1. On 3/25/19 starting at 12:18 PM, observations were made in the assisted dining room on the second floor. A pool of spilled water was on the floor next to Resident #55. CNA #4 wiped up the spilled water from the floor using her bare hands and paper towels. CNA #4 then walked across the room and discarded the used paper towels in the trash. CNA #4 did not perform hand hygiene after discarding the dirty paper towels. She then obtained a clean paper towel, returned to Resident #55, and handed the clean paper towel to her. CNA #4 then immediately assisted another female resident at the next table to her right without performing hand hygiene, then CNA #4 picked up a drink from the table and handed it to the female resident.</p> <p>On 3/25/19 at 12:25 PM, CNA #4 said she did not sanitize her hands at the appropriate times as previously described, and she should have.</p> <p>On 3/27/19 at 3:02 PM, the DON said she expected CNA #4 to wash her hands after she cleaned up water from the floor and after she touched something that a resident had touched, and before assisting another resident.</p> <p>2. The facility's policy for Urinary Catheter Care, dated 2018, directed staff to "cleanse and rinse the catheter from insertion site to approximately 4</p>	F 880	<p>acidic acid soak, and prior to donning gloves to cut the Vac foam and drape, prior to applying skin prep and and application of the Vac drape. She stated that she changed gloves so frequently due to ill fitting gloves and did acknowledge that after she had partially secured the Vac drape she changed into a clean pair of sterile gloves as the sterile gloves fit her better and allowed for her to get a proper fit of the Vac foam and drape. She states that she did not break her clean field. She states she removed the gloves and washed her hands before applying gloves to secure the tubing and vac canister to the machine. She acknowledged that she understands the need to wash her hands with any glove change per CDC guidelines. Wound Nurse has been provided with gloves that appropriately fit her hands to prevent unnecessary glove changes.</p> <p>Unable to correct the deficient practice for the residents identified as they were actions done in the past by staff.</p> <p>2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;</p> <p>All residents are at risk of the deficient practice. Nursing staff received in-service education regarding proper hand hygiene including the proper use of gloves and</p>		

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F 880	<p>Continued From page 54 inches outward."</p> <p>Resident #232 was admitted to the facility on 3/13/19, with multiple diagnoses including hemiplegia and hemiparesis (weakness and paralysis on one side of the body) following a stroke, neuromuscular dysfunction of the bladder (a disorder of the urinary tract caused by damage or disease of the nervous system), chronic kidney disease, and an unstageable pressure ulcer of the right heel.</p> <p>Resident #232's physician orders, dated 3/27/19, included a suprapubic catheter (a catheter inserted through the lower abdominal wall) 16 FR (the size of the catheter) for neurogenic bladder.</p> <p>On 3/27/19 at 9:21 AM, CNA #3 performed catheter care for Resident #232's suprapubic catheter. CNA #3 cleansed around the insertion site of the catheter (on the lower abdomen). Using a pre-packaged wipe, CNA #3 then cleansed the catheter by starting nearest to the insertion site. CNA #3 wiped the catheter moving away from the insertion site, and using the same wipe CNA #3 wiped the catheter back up towards the insertion site. CNA #3 repeated this action two more times, which was not consistent with the facility's policy to wipe from the catheter's insertion site to approximately 4 inches outward.</p> <p>On 3/27/19 at 9:29 AM, CNA #3 said she should perform catheter care by first cleaning closer to the skin then moving out and away from possible infection. CNA #3 said she might have wiped Resident #232's catheter back the other way and she</p>	F 880	<p>when hands should be washed from the DON or designee on or before 4/30/19</p> <p>Nursing staff received education regarding Foley catheter care from the DON or designee on or before 4/30/19</p> <p>3.) What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.</p> <p>Direct care staff have been educated by DON or designee on or before 4/30/19 regarding the current infection control guidelines recognized by the CDC and incorporated into the updated Requirements of Participation for Skilled Nursing Facilities.</p> <p>Nursing staff received education regarding proper Foley catheter care from the DON or designee on or before 4/30/19</p> <p>Upon hire and annually nursing staff will receive facility provided infection control education to ensure understanding and competency.</p> <p>4.) Indicate how the corrective action(s) will be monitored to ensure the corrective action(s) are effective and compliance is sustained will not recur.</p> <p>Beginning the week of 5/1/19 DON or</p>		

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F 880	<p>Continued From page 55 should not have.</p> <p>On 3/27/19 at 3:03 PM, the DON said catheter care should be performed by wiping in one direction, away from the catheter insertion site.</p> <p>3. Resident #232's physician orders documented detailed wound care was ordered for her right heel on 3/25/19.</p> <p>Resident #232's care plan documented she had a Stage IV pressure injury (full thickness tissue loss with exposed muscle, tendon, or bone) to her right heel, initiated on 3/13/19 and revised on 3/20/19. Interventions included a wound vacuum (a device that removes pressure over a wound area by using negative pressure).</p> <p>On 3/25/19 starting at 3:14 PM, the Wound Nurse performed wound care to the pressure ulcer on Resident #232's right heel. The Wound Nurse put on clean gloves and removed Resident #232's compression stocking and the dressing from her right lower leg. The Wound Nurse measured the wound and applied a gauze soaked in Acetic Acid (a chemical used to help with wound healing) to Resident #232's wound. Wearing the same gloves she used to remove the dirty wound dressing, The Wound Nurse then opened dressing supplies, applied skin prep to the skin around the wound, and applied the vacuum drape (dressing material used to help hold the wound vacuum in place). The Wound Nurse removed her gloves and did not perform hand hygiene, then opened a package of clean dressing material. She then washed her hands, applied new gloves, cut the dressing material and applied it around Resident #232's wound. The</p>	F 880	<p>designee will complete rounds and to ensure compliance with focus on handwashing, meal service and hand sanitization between glove changes. Rounds will be completed 5 times weekly for 4 weeks, then 2 times weekly for 8 weeks. Identified concerns will be corrected at the time identified, as possible & referred to DON for resolution.</p> <p>Beginning week of 5/1/19 DON or designee will observe CNA complete urinary catheter care to ensure compliance. Will complete 2 CNA observations weekly x 4 weeks, then 2 observations bi-weekly x 1 month, then monthly x 3 months.</p> <p>Results of the rounds will be presented in the facility QAPI meeting for three months (or longer as necessary) beginning in June, with any identified negative trends addressed through system modification and staff education as appropriate</p>		

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F 880	<p>Continued From page 56</p> <p>Wound Nurse removed her gloves and did not perform hand hygiene, applied new gloves, and cut the vacuum drape dressing. She removed her gloves and did not perform hand hygiene, then applied sterile gloves. The Wound Nurse proceeded with completing dressing the wound and removed her gloves, then went to wash her hands in the bathroom. The Wound Nurse applied new gloves, cut and applied more vac drape, picked up the tubing for the wound vacuum, connected the tubing to a new canister, cut a hole in the vac drape, secured the tubing on top of the vac drape, inserted the new canister into the wound vacuum machine, turned on the machine, removed her gloves, did not perform hand hygiene, applied a new glove to one hand, and discarded the remaining dressing supplies.</p> <p>The Wound Nurse did not perform hand hygiene on 4 opportunities after removing her gloves during Resident #232's dressing change.</p> <p>On 3/25/19 at 4:08 PM, The Wound Nurse said hand hygiene should be performed before starting wound care, after removing the dressing, after changing the dressing, and before touching the wound if another part of the body was touched. The Wound Nurse said if you touch something you should wash your hands. The Wound Nurse said she did not perform hand hygiene between removing clean gloves and applying sterile gloves because it was not a sterile procedure. The Wound Nurse said she was still clean because she did not touch anything that was dirty in between changing gloves.</p> <p>On 3/29/19 at 9:36 AM, LPN #2, who was filling</p>	F 880			

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

PRINTED: 04/29/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/29/2019
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F 880	Continued From page 57 in for the Infection Control Nurse, said hand hygiene should be performed before gloves were applied and after they were removed, and in between changing gloves.	F 880			

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135098	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 3/29/2019
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NAME OF PROVIDER OR SUPPLIER VALLEY VIEW NURSING & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1140 NORTH ALLUMBAUGH STREET BOISE, ID
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 842	<p>Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)</p> <p>§483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <ul style="list-style-type: none"> (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized <p>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <ul style="list-style-type: none"> (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <ul style="list-style-type: none"> (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. <p>§483.70(i)(5) The medical record must contain-</p> <ul style="list-style-type: none"> (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
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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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135098	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 3/29/2019
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 842	<p>Continued From Page 1</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure accurate and complete clinical records were maintained for each resident. This was true for 1 of 19 residents (Resident #82) whose records were reviewed. Findings include:</p> <p>Resident #82 was admitted to the facility on 2/7/19, with multiple diagnoses including acute respiratory failure with hypoxia (low oxygen level in the blood) and lymphoma (a type of cancer).</p> <p>A Progress Note, dated 3/7/19 at 9:17 AM, documented Resident #82 was without vital signs at 7:45 AM. The family and hospice were notified, and the body was to be released to a named funeral home.</p> <p>Resident #82's Record of Death and Mortician's Receipt documented Resident #82 died on 3/7/19 at 7:45 AM. There was no information documented in the following areas: Attending Physician notification, Mortician requested by/Called by, Mortician's Receipt, and the signature/title of the nurse releasing the body.</p> <p>On 3/29/19 at 2:13 PM, the DON acknowledged there were blank areas on the Record of Death and Mortician's Receipt, and said whoever retrieved the form should have completed it.</p>		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN – Director

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June 19, 2019

Jordan Thompson, Administrator
Valley View Nursing & Rehabilitation
1140 North Allumbaugh Street,
Boise, ID 83704-8700

Provider #: 135098

Dear Mr. Thompson:

On **March 29, 2019**, an unannounced on-site complaint survey was conducted at Valley View Nursing & Rehabilitation. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007873

ALLEGATION #1:

A resident stated an aide was physically and verbally abusive while assisting them and they received a skin injury.

FINDINGS #1:

An unannounced complaint and recertification survey was conducted on 3/25/19 through 3/29/19.

During the investigation 19 residents' records which included three closed records were reviewed for Quality of Care, abuse and neglect. Staff members were interviewed and observed as they provided care and services to the residents, and staff interactions with the residents were also observed. The facility's abuse allegations were reviewed.

One discharged resident's record documented she was readmitted in 9/2017. The record

documented the resident was cognitively intact and able to communicate with others using a tool.

An Incident and Accident (I&A) report documented the resident was being transferred from her wheelchair to the shower chair when she was observed to have a skin tear on the knuckle of her right hand above her index finger. The I&A report documented a hospice Certified Nursing Assistant (CNA) was assisting the resident and said she did not know how the resident got the skin tear.

An Interdisciplinary Team (IDT) note documented the resident had thin, fragile skin and her arms and hands were contracted toward her body. The note stated it was likely her hand got scratched on the hospice CNA's name badge causing the skin tear. The IDT note documented the hospice CNA was going to be educated not to use a name badge while transferring and showering a resident.

A hospice nurse report documented the resident had difficulty with speech but was able to communicate. The report documented the resident said the skin tear was not an accident and the hospice CNA was rough with her and was trying to get her to hold onto a bar but she was not able to do that.

An Investigation Report from the hospice agency documented the hospice CNA was not the usual CNA who assisted the resident. The hospice's investigation report documented the hospice CNA would be given a disciplinary action and education related to the incident. The report also documented the facility requested not to send another hospice CNA when the usual hospice CNA of the resident was not available, and facility was going to provide personal cares to the resident using the facility's bath aide. The hospice's investigation report also documented the resident's family was happy with the result of their investigation.

A Licensed Practical Nurse (LPN) said she assessed the resident after it was reported to her the resident had a skin tear and she did not remember the resident was in any kind of distress. The LPN said she did not think it was an abuse case but it was an accident.

The facility's bath aide said when she walked into the shower room, she did not hear any yelling. She said she did not see how the resident got the skin tear. The CNA also stated she was close to the resident and the resident did not say anything to her. The CNA said she did not see signs of distress with the resident on that day.

CONCLUSIONS:

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

ALLEGATION #2:

The facility's staff were not knowledgeable about the resident's condition.

FINDINGS #2:

During the investigation resident records were reviewed, Incident and Accident reports were reviewed, and facility grievances were reviewed. Staff were interviewed and observed as they provided care and services to the residents.

One resident's record documented she had a progressive neurological disorder which effected movement and involuntary actions. A grievance report documented the resident's family felt the resident was forced to eat by staff and they were not knowledgeable about the resident's disease.

An LPN said she provided an in-service training with all the staff regarding the resident's condition. The LPN said the resident ate in the assisted dining room and reminded the staff not to force the resident to eat if she does not want to eat. The resident was able to indicate how much she liked to eat and when she liked to stop.

CONCLUSIONS:

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

ALLEGATION #3:

The resident was not provided with assistance by two staff during her Activities of Daily Living (ADL).

FINDINGS #3:

During the investigation, resident records were reviewed, grievances were reviewed, and staff were interviewed and observed as they provided care and services to the residents.

One resident's medical record documented she needed extensive assistance of one person for bathing/showering, bed mobility, dressing, personal hygiene and eating, and she used a wheelchair for locomotion.

The resident's record documented her representative was given a copy of the care plan for the resident on two occasions, one in 4/2018 and in 6/2018 for her review. There was no documentation in the Social Worker's progress notes the resident's representative requested two staff members to assist the resident with her ADLs.

The Director of Nursing (DON) said she remembered the resident was able to pivot during transfers. The DON stated according to their assessment the resident required extensive assistance of one staff. The DON said she was not made aware the family requested two staff assist for the resident during their care plan conference. The DON said the Social Worker who attended the care plan conference with the resident's representative was no longer in the facility.

CONCLUSIONS:

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

ALLEGATION #4:

The facility did not use the shirt protectors provided by a resident's family to help keep her clean and did not do her hair the way she liked.

FINDINGS #4:

During the investigation resident records were reviewed, grievances were reviewed, and staff were interviewed and observed as they provided care and services to the residents. Residents were interviewed and observed for Quality of Care.

One resident's record documented she needed extensive assistance of one person for bathing/showering, bed mobility, dressing, personal hygiene and eating, and she used a wheelchair for locomotion. A nurse's note documented the resident's family brought in a bib for the resident to wear to help prevent her secretions from soiling her clothing and getting on her chest. The resident's care plan was not updated and did not include the use of the clothing protector as requested by the family.

Residents eating in the dining room were observed to be appropriately groomed, hair combed, and clothes clean. Some residents were provided with and wore a clothing protector while dining.

A resident who was cognitively impaired was observed in her room sitting on her recliner by her window. Her hair was neatly combed, and her clothes were clean. The resident's teeth were observed to be cleaned. Residents who needed assistance with their personal hygiene and dressing said they were being assisted by the staff and they had no concerns.

CONCLUSIONS:

Based on the investigative findings, the allegation could not be substantiated, however the facility was cited under F657 for not updating the resident's care plan related to the use of a clothing protector.

ALLEGATION #5:

The family submitted a grievance and did not receive a response or follow-up from the facility regarding their grievance.

FINDINGS #5:

During the investigation, resident records were reviewed, facility grievances were reviewed, and staff were interviewed and observed as they provided care and services to the residents. Residents were also interviewed and observed for Quality of Care.

One grievance report documented a resident's family representative filed two grievances regarding knowledge of the resident's disease, assistance with personal hygiene and grooming, and availability of medications. The grievances were as follows:

- A grievance documented the resident was not provided with showers, she was forced to eat, and staff were not knowledgeable about her disease condition. The grievance report documented the resident's record was reviewed, and it included documentation showers were provided to her. Staff were in-serviced on dignity, cleaning residents' face and hands after eating, and on this resident's disease process and condition.

- A second grievance report documented the following:

* A resident was not sufficiently groomed and appeared dirty for her medical appointment.

* Medication was not filled on the day of her surgery.

* Staff were not rinsing off the feces from her soiled clothes and mixed the soiled clothes with other dirty clothes to be sent home with her family.

The grievance report documented staff were assisting in the dining room and were not aware of the resident's appointment, and her medication was ordered but did not arrive in time. The grievance report documented staff were unable to determine who was not cleaning off the feces on the resident's clothes before sending them home to her family.

The grievance report documented staff were educated about ensuring residents appeared appropriate for medical appointments, and not to send the resident's clothes before removing the feces.

The grievance reports did not include documentation the resident's family representative was notified of the resolution of their grievances or were provided a report of the facility's

Jordan Thompson, Administrator
June 19, 2019
Page 6

investigative findings.

An LPN said she did an in-service training with the staff regarding the grievances and submitted it to the Staff Development Coordinator.

The DON said if she was the one assigned to investigate a grievance, she notified the resident or person who filed the grievance of her findings

The Administrator said all grievances were submitted to the Grievance Officer and were reviewed during their morning stand-up meeting. The Administrator said the grievances were distributed to different departments based on the type of grievance. The Administrator said the person responsible for investigating the grievance should inform the resident or their representative of their investigative findings or how the grievance was addressed.

CONCLUSIONS:

Based on the investigative findings, the allegation was substantiated and the facility was cited at F585 related to the facility failure's to notify the family of the result of the investigation regarding their grievances.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

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

Sincerely,



LAURA THOMPSON, RN, Supervisor
Long Term Care Program

Jordan Thompson, Administrator
June 19, 2019
Page 7

LT/slj