



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

June 20, 2019

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

Provider #: 135068

Dear Mr. Lewis, Jr.:

On **June 7, 2019**, a survey was conducted at Parke View Rehabilitation & Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 1, 2019**. Failure to submit an acceptable PoC by **July 1, 2019**, may result in the imposition of penalties by **July 23, 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 **July 12, 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 **September 7, 2019**. A change in the seriousness of the deficiencies on **July 22, 2019**, may result in a change in the remedy.

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June 20, 2019  
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The remedy, which will be recommended if substantial compliance has not been achieved by **September 7, 2019** includes the following:

Denial of payment for new admissions effective **September 7, 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 **December 7, 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, Long Term Care Supervisors, 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 **September 7, 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:

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

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

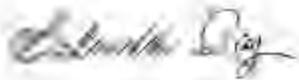
- BFS Letters (06/30/11)

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

This request must be received by **July 1, 2019**. If your request for informal dispute resolution is received after **July 1, 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/lj

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

PRINTED: 07/03/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135068</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/07/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARKE VIEW REHABILITATION &amp; CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2303 PARKE AVENUE BURLEY, ID 83318</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from June 3, 2019 through June 7, 2019.  The surveyors conducting the survey were: Edith Cecil, RN, Team Coordinator Presie Billington, RN Karen Gray, RD  Survey Abbreviations: CNA = Certified Nursing Assistant DON = Director of Nursing LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment mg = milligrams RN = Registered Nurse	F 000			
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)  §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.  §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.  §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to	F 578		7/5/19	

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

TITLE

(X6) DATE

Electronically Signed

06/28/2019

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 578	Continued From page 1 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 and staff interview, it was determined the facility failed to ensure residents received information and assistance to exercise their right to formulate an Advance Directive. This was true for 5 of 16 residents (#10, #31, #34, #56, and #65) reviewed for Advance Directives. The deficient practice created the potential for harm should residents' wishes regarding end of life or emergent care not be honored if they were incapacitated. Findings include:	F 578	The Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Parke View Rehabilitation & Care Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and		

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F 578	Continued From page 2 Resident #10, Resident #31, Resident #34, Resident #56, and Resident #65 did not have a copy of an Advance Directive in their records. The five residents' medical records did not include documentation an Advanced Directive was discussed with them. Additionally, the residents' medical records did not include documentation they were provided assistance to formulate an Advance Directive, or of their decision not to formulate an Advance Directive.  On 6/6/19 at 3:30 PM, the LSW stated she talked to the residents about creating Advance Directives, however, she did not always document her conversations.  On 6/6/19 at 4:00 PM, the Administrator stated he was sure the LSW talked to the residents about Living Wills and DPOAs (Durable Power of Attorney for Healthcare) and if a copy was provided it was kept in the residents' hardcopy charts.  On 6/7/19 at 9:00 AM, the LSW confirmed she had no further documentation regarding Advance Directives for the five residents.	F 578	conclusions that form the basis for the deficiency.  1. Affected residents were given information offered assistance to exercise their right to formulate an advanced directive. 2. All residents have the potential to be affected. Audit to be done to determine all current residents who do not have advanced directives. Information will be provided and assistance to exercise their right to formulate an advanced directive will be offered. 3. Social Worker inserviced on advanced directive regulation. Documentation that advanced directives are being discussed during quarterly care plan review to be added. 4. Administrator or designee to audit documentation of advanced directive discussions monthly for 4 months. These audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.		
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	F 623		7/5/19	

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F 623	<p>Continued From page 3</p> <p>Long-Term Care Ombudsman.</p> <p>(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</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(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.</p> <p>(ii) Notice must be made as soon as practicable 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>	F 623			

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F 623	<p>Continued From page 4</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 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</p> <p>(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</p>	F 623			

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F 623	<p>Continued From page 5</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, review of admission agreement paperwork, and record review, it was determined the facility failed to ensure transfer notices were provided in writing to residents upon transfer. This was true for 1 of 2 residents (Resident #21) reviewed for transfers. This deficient practice had the potential for harm if residents were not made aware of or able to exercise their rights related to transfers. Findings include:</p> <p>The facility's Resident Admission Agreement documented if a more immediate transfer or discharge was required due to urgent medical need, a written notice of transfer was given to the resident or their representative as soon as practicable before the transfer or discharge.</p> <p>Resident #21 was admitted to the facility on 11/21/18, with unspecified dementia with behavioral disturbance.</p> <p>A discharge MDS assessment, dated 2/22/19, documented Resident #21 was discharged to a hospital. She was readmitted from the hospital on 2/28/19.</p> <p>Resident #21's medical record did not include documentation she or her responsible party were provided a transfer notice. On 6/6/19 at 10:49</p>	F 623	<ol style="list-style-type: none"> <li>1. Affected resident's family was given transfer/discharge information in writing.</li> <li>2. All residents have the potential to be affected. All discharges for the last month to be audited to verify transfer/discharge information was given in writing and sent to them if documentation is not found.</li> <li>3. Licensed nursing staff to be inserviced regarding the transfer/discharge requirements.</li> <li>4. Medical Records Manager will audit all discharges weekly for 4 weeks, monthly for 3 months. These audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.</li> </ol>		

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F 623	Continued From page 6 AM, the Director of Medical Records stated the transfer and the reason for the transfer was communicated by telephone to the resident and her responsible party.	F 623			
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)  §483.15(d) Notice of bed-hold policy and return-  §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- (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; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (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 (iv) The information specified in paragraph (e)(1) of this section.  §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing 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: Based on policy review, record review, and staff	F 625	1. Affected resident's family was given	7/5/19	

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F 625	<p>Continued From page 7</p> <p>interview, 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 1 of 2 residents (Resident #21) reviewed for transfers. 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 Bed-Hold/Reservation of Room policy, dated 9/2017, documented the resident, or the resident's representative, would be informed, in writing, of their right to exercise the bed-hold provision. The notice was to include the following:</p> <p>* The duration of the state bed-hold policy (if any) and/or the facility policy that the resident's bed will be held for the duration of 3 days, during which time the resident was permitted to return and resume residence in the facility.</p> <p>* The amount required to be paid by the resident or the resident's payor source to hold the bed for the duration of the bed-hold period.</p> <p>* This information would be provided to the resident and/or their representative in a language they could understand at the time of admission and transfer to the general acute hospital.</p> <p>Resident #21 was admitted to the facility on 11/21/18, with dementia.</p> <p>A discharge MDS assessment, dated 2/22/19,</p>	F 625	<p>bed hold information in writing.</p> <p>2. All residents have the potential to be affected. All discharges for the last month to be audited to verify bed hold information was given in writing and sent to them if documentation is not found.</p> <p>3. Licensed nursing staff to be inserviced regarding the bed hold requirements.</p> <p>4. Medical Records Manager will audit all discharges weekly for 4 weeks, monthly for 3 months. These audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 625	Continued From page 8 documented Resident #21 was discharged to a hospital. She was readmitted from the hospital on 2/28/19. She was readmitted from the hospital on 2/28/19.  A Notification of Bed-Hold Policy and Readmission form, dated 2/22/19, documented Resident #21 was discharged to an acute care hospital. The form documented the resident's bed would be held without charge for 3 days and to notify the Business Office Manager for a room rate if the bed-hold exceeded 3 days.  The form documented Resident #21 and her responsible party were notified of the policy and terms via telephone on 2/22/19 at 11:57 PM. The resident and the responsible party signature lines were blank.  On 6/6/19 at 10:49 AM, the Director of Medical Records stated she did not have a bed-hold notice signed by the resident or her representative.	F 625			
F 684 SS=D	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, it	F 684	1. Resident #40 had bowel care protocol	7/5/19	

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F 684	<p>Continued From page 9</p> <p>was determined the facility failed to ensure professional standards of practice were followed for medication and CPAP (Continuous Positive Airway Pressure) administration. This was true for 1 of 3 residents (Resident #40) reviewed for bowel care . This failed practice created the potential for residents to experience complications related to constipation (Resident #40) if they did not receive the necessary treatment. Findings include:</p> <p>Resident #40 was admitted to the facility on 3/4/19, with multiple diagnoses which included chronic kidney disease.</p> <p>A quarterly MDS assessment, dated 4/29/19, documented Resident #40 had severe cognitive impairment, required extensive two person assistance for toileting, and was continent of bowel.</p> <p>Resident #40's physician orders, dated 3/4/19, included the following:</p> <ul style="list-style-type: none"> <li>* Biscolax suppository 10 mg, insert one rectally as needed for bowel care.</li> <li>* Glycolax Powder, give 17 gms by mouth as needed for bowel care.</li> <li>* Milk of Magnesia, give 30 mls by mouth as needed for bowel care.</li> </ul> <p>Resident #40's physician's order, dated 4/16/19, directed staff to provide Colace 100 mg, 1 capsule by mouth two times a day for constipation.</p>	F 684	<p>added to their medical record.</p> <p>2. All residents have the potential to be affected. Audit done to determine residents who did not have a bowel protocol in their medical record. Bowel protocol was added to all residents' routine standing orders.</p> <p>3. Licensed nurses to be inserviced on bowel protocol.</p> <p>4. DNS or designee will audit bowel documentation weekly for 4 weeks, monthly for 3 months. These audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.</p>		

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F 684	Continued From page 10 Resident #40's MARs from 5/9/19 to 5/14/19, did not include documentation bowel care medications were provided as ordered by the MD as follows:  * From 5/9/19 through 5/14/19, Resident #40 did not have a bowel movement (6 days). Resident #40's MAR did not include documentation the Biscolax suppository, Glycolax Powder, or Milk of Magnesia were administered.  On 6/7/19 at 12:44 PM, the DON stated the facility did not have a policy for bowel care or a protocol for bowel care. She stated the facility had standing physician orders and let the resident choose what they want for bowel care.	F 684			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)  § 483.25(i) Respiratory care, including 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: Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to; a) ensure staff stored the nebulizer mouthpiece appropriately after each use and let it dry and b) ensure professional standards of practice were followed for CPAP (Continuous Positive Airway Pressure) administration This was true for 1 of 1 resident	F 695	1. CPAP was assessed by Norco to verify that it was functioning properly. Resident #64's physician was notified of the refusal and he discontinued CPAP. 2. All residents who use a CPAP or nebulizer have the potential to be affected. Audit was done of all current CPAPs and nebulizers that they were	7/5/19	

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F 695	<p>Continued From page 11 (Resident #64) reviewed for respiratory care. This failure placed residents at risk of respiratory infections due to the growth of pathogens (organisms that cause illness) in the respiratory equipment and increased respiratory problems if they did not receive the necessary treatment. Findings include:</p> <p>Resident #64 was admitted to the facility on 5/2/19, with multiple diagnoses which included chronic obstructive pulmonary disease (progressive lung disease characterized by increasing breathlessness).</p> <p>a. The facility's Use and Care of Nebulizer Equipment policy, revised on 7/17, directed staff to:</p> <ul style="list-style-type: none"> <li>* Remove the mouthpiece from the T-piece, the T-piece from the nebulizer cap, unscrew the nebulizer cap from the nebulizer jar and remove the nebulizer jet (if it is removable), and disconnect the nebulizer jar from the air tubing.</li> <li>* Rinse all of the disassembled nebulizer parts with water and allow to air dry on a clean towel before using the pieces again.</li> </ul> <p>On 6/3/19 at 11:36 AM, 6/4/19 at 4:28 PM and 6/5/19 at 4:13 PM, Resident #64's nebulizer mouthpiece was observed resting on top of her nebulizer machine which was on top of her bedside table.</p> <p>On 6/5/19 at 4:17 PM, LPN #2 was shown Resident #64's mouthpiece resting on top of the nebulizer machine. LPN #2 removed the mouthpiece and the nebulizer cap and washed it.</p>	F 695	<p>being stored properly and that the physicians were being notified of CPAP usage refusals.</p> <p>3. Licensed nurses were inserviced on storage and care of nebulizers. Licensed nurses were inserviced on the process of refusals of CPAPs and notifying the physician.</p> <p>4. DNS or designee will audit nebulizer use and storage weekly for 4 weeks and monthly for 3 months. DNS or designee will audit CPAP refusals weekly for 4 weeks and monthly for 3 months. These audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.</p>		

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F 695	<p>Continued From page 12</p> <p>LPN #2 said the nebulizer mouth piece and nebulizer cap should be washed after each use, air dried and placed in a plastic bag.</p> <p>b. Resident #64's admission MDS assessment, dated 5/14/19, documented she used a CPAP machine.</p> <p>A care plan, initiated on 5/6/19, directed staff to administer Resident #64's CPAP machine at night and when necessary.</p> <p>a. Resident #64's 5/6/19 through 6/4/19 TAR, documented "CPAP at home setting at night and PRN." The TAR documented Resident #64 refused to use her CPAP machine on 18 out of 30 opportunities.</p> <p>A Nursing Note, dated 5/10/19 at 11:36 PM, documented Resident #64 refused to use her CPAP machine multiple times. The note documented Resident #64 stated it made her cough and did not like the way it made her feel.</p> <p>A Nursing Note, dated 5/15/19 at 1:40 AM, documented Resident #64 refused to use her CPAP machine due to her cough. The note stated the nurse asked Resident #64 if she would like to inform the physician and discontinue her CPAP machine. Resident #64 said she would like to use it once she felt better.</p> <p>On 6/5/19 at 5:48 PM, the ADON reviewed Resident #64's TAR and said Resident #64's physician should have been notified of her continued refusals to use her CPAP machine. The ADON said she did not find documentation Resident #64's physician was notified.</p>	F 695			

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F 695	Continued From page 13  b. On 6/3/19 at 11:36 AM, a CPAP machine was observed on top of Resident #64's left bedside table. Resident #64 said the staff was not able to make her CPAP machine work the night before and she was not able to use it.  On 6/4/19 at 4:28 PM, Resident #64 said she did not use her CPAP machine the night before because it was not working, but she found out that morning it was not plugged into the wall outlet. Resident #64 pointed to the cord and said it was behind the table the night before.  On 6/5/19 at 4:17 PM, Resident #64 told LPN #2 she found the cord for her CPAP machine and she hoped she could use it that night. On 6/5/19 at 4:22 PM, LPN #2 said the nurse set-up residents' CPAP machines, and she did not know why Resident #64 was unable to use hers the previous two nights.	F 695			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)  §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  §483.45(h) Storage of Drugs and Biologicals  §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		7/5/19	

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F 761	<p>Continued From page 14 personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure pharmacy labels were on resident medications prior to use. This was true for 1 of 4 residents (Resident #275) reviewed for medication storage and labeling. This failed practice created the potential for residents to receive unidentified or expired medications. Findings include:  The facility's policy and procedure for Services of a Licensed Pharmacist, dated 8/2017, documented the pharmacist was responsible for pharmaceutical services that were consistent with current standards of practice and met state and federal requirements.  Resident #275 was admitted from home to the facility on 6/6/19, for a five-day respite under hospice care.  On 6/7/19 at 10:34 AM, an inspection of the 500 Hall medication cart was completed with LPN #1 present. The medication cart contained 25 medication cards for Resident #275. The</p>	F 761	<ol style="list-style-type: none"> <li>1. The labels for medications for resident #275 were changed to have the proper labeling</li> <li>2. All residents have the potential to be affected. All medications were audited to ensure proper labeling.</li> <li>3. Licensed nurses were inserviced on proper labeling of medications.</li> <li>4. DNS or designee will audit medication labeling weekly for 4 weeks and monthly for 3 months. These audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.</li> </ol>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 761	<p>Continued From page 15 medication cards did not have a pharmacy label.</p> <p>Each medication card had a white sticker on the front with the resident's name, date of birth, the name of the medication, and direction for use. This information was handwritten. The back of the medication card included an area for the pharmacy to fill in the following information:</p> <ul style="list-style-type: none"> <li>* Filled by/checked by</li> <li>* Medication</li> <li>* Strength</li> <li>* Lot Number</li> <li>* Expiration Date</li> <li>* Manufacturer</li> </ul> <p>The above information was not filled in on the medication cards.</p> <p>The hospice agency provided Resident #275's medications for his respite stay. The medications included Lorazepam, a sedative useful for anxiety; hydrocodone-acetaminophen, a narcotic for pain management; warfarin, a blood thinner; and furosemide, a diuretic. There were also cardiac medications and 2 insulin pens for diabetes mellitus. The medication cards did not provide warnings about side effects, possible drug interaction, precautions during use, a description of the medication, or the expiration date.</p> <p>At 10:50 AM, the DON viewed the medication cards for Resident #275. She confirmed she could not ensure the medications inside the cards matched the labels or when they expired.</p>	F 761			
F 880 SS=D	<p>Infection Prevention &amp; Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p>	F 880			7/5/19

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F 880	Continued From page 16  §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 §483.70(e) and following accepted national standards;  §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880			

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F 880	<p>Continued From page 17</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (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 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, staff interview and policy review, it was determined the facility failed to ensure a glucometer used to check blood glucose levels was cleaned after each use. This was true for 2 of 3 residents (#44 and #64) observed for blood glucose testing. This deficient practice created the potential for the spread of infectious organisms from cross contamination</p>	F 880	<ol style="list-style-type: none"> <li>1. Licensed Nurse #3 was inserviced regarding glucometer usage and disinfecting with return demonstration.</li> <li>2. All residents have the potential to affected. Glucometer care was observed for licensed nurses.</li> <li>3. Licensed nurses inserviced regarding care of blood glucose meter.</li> </ol>		

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F 880	<p>Continued From page 18 which could harm all residents in the facility.</p> <p>The facility's Care of the Blood Glucose Meter Policy, dated 10/14/10, directed staff to clean the outside of the meter per the manufacturer's guidelines, before initial use, and after every patient.</p> <p>On 6/4/19 at 4:35 PM, LPN #3 was observed performing a capillary blood glucose test to Resident #64 using a glucometer. After the completion of the capillary blood glucose test, LPN #3 placed the glucometer inside a plastic cup, removed her gloves and washed her hands. LPN #3 picked up the plastic cup, returned to the medication cart, placed the plastic cup on top of the medication cart, and wrote the result of Resident #64's blood glucose on a sticky note pad. LPN #3 was not observed to sanitize the glucometer.</p> <p>On 6/4/19 at 4:42 PM, LPN #3 was observed performing a capillary blood glucose test to Resident #44 using the same glucometer she used for Resident #64. After the completion of the capillary blood glucose test, LPN #3 placed the glucometer on a paper towel on top of Resident #44's overbed table. She removed her gloves and washed her hands. LPN #3 picked up the glucometer, placed it in a plastic cup and returned to the medication cart. She placed the plastic cup on top of the medication cart and started charting. LPN #3 did not sanitize the glucometer before using it for Resident #44.</p> <p>On 6/4/19 at 4:54 PM, LPN #3 said she used a multi-use glucometer and she did not sanitize it between uses. LPN #3 said she thought she did</p>	F 880	4. DNS or designee will audit glucose meter care with nurses weekly for 4 weeks and monthly for 3 months. These audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.		

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F 880	Continued From page 19 not need to sanitize the glucometer if she placed it on top of a barrier when she was inside the resident's room.	F 880			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001580</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/07/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PARKE VIEW REHABILITATION &amp; CARE CENTI</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2303 PARKE AVENUE BURLEY, ID 83318</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS  The following deficiency was cited during the state licensure survey conducted at the facility from June 3, 2019 through June 7, 2019.  The surveyors conducting the survey were:  Edith Cecil, RN, Team Coordinator Presie C. Billington, RN	C 000		
C 409	02.120,05,i Required Room Closet Space  i. Closet space in each sleeping room shall be twenty inches by twenty-two inches (20" x 22") per patient/resident. Common closets utilized by two (2) or more patients/residents shall be provided with substantial dividers for separation of each patient's/resident's clothing for prevention of cross contamination. All closets shall be equipped with doors. Freestanding closets shall be deducted from the square footage in the sleeping room. This Rule is not met as evidenced by: Based on observation and resident and staff interview, it was determined 21 of 21 residents' closets on the North Wing (Room #s 110, 112, 117, 118, 119, 120, 122, 124, 125, 126, 127, 128, 129, 130, 131, and 132) did not meet closet space requirements. Findings include:  On 6/7/19 from 10:00 to 10:30 AM, observations and resident interviews identified the unmet closet requirement did not negatively impact resident's quality of life.	C 409	Parke View Rehabilitation & Care Center is requesting to continue the waiver for the closet space requirement on the North Wing.	7/5/19

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>06/28/19</b>
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001580</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/07/2019</b>
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C 409	<p>Continued From page 1</p> <p>Resident #15 said it would be nice if she could have another rod installed in her closet so she could hang more clothes.</p> <p>On 6/7/19 at 11:00 AM, the Administrator was informed of Resident #15's request. He stated he was going to request the maintenance department install another rod in Resident #15's closet. The Administrator said the facility was also going to again request a waiver for the closet space requirement.</p>	C 409		



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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DAVE JEPPESEN – Director

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LICENSING & CERTIFICATION  
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July 23, 2019

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

Provider #: 135068

Dear Mr. Lewis, Jr.:

On **June 3, 2019** through **June 7, 2019**, an unannounced on-site complaint survey was conducted at Parke View Rehabilitation & Care Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007963**

**ALLEGATION #1:**

Residents were not being bathed and appropriately groomed.

**FINDINGS #1:**

During the investigation the clinical records of 19 residents including one closed record were reviewed for the frequency of shower/baths, facility grievance files and Incident & Accident reports were reviewed, Resident Council minutes were reviewed, observations were conducted, and residents and staff were interviewed.

The facility's Grievance files from January 2019 to May 2019, did not include documentation of concerns related to bathing or showers. Resident Council meeting minutes from March 2019 to May 2019 were reviewed. Concerns related to the frequency of shower/baths were not documented in the meeting minutes. The facility's Incidents and Accidents reports from January 2019 to May 2019, did not include documentation of concerns related to bathing or showering.

Observations were conducted of residents' dining, peri-care, finger and toenail length, hooyer lift transfers, dentures, medication administration and staffs interactions with the residents. Toenails and fingernails were observed and they were clean and trimmed. There were no concerns identified during the observations.

Nine residents were individually interviewed and did not express concerns related to their showers/baths not being provided. Twelve residents attended the group interview with the surveyors and none expressed not receiving their shower/bath or appropriate grooming.

Showers/Baths were provided by the Certified Nursing Assistants (CNA), and the CNAs said they made sure residents received their showers/baths as scheduled, and if a resident refused they went back to the resident two more times and if they continued to refuse, the nurse was notified.

One resident's record documented she was admitted to the hospital intermittently on 10/8/19 through 10/22/18, and on 11/1/18 through 11/8/18. The resident's shower/bath record dated 9/30/18 through 10/7/18, 10/23/18 through 10/31/18, and 11/9/18 through 12/12/18, documented the resident was provided a shower or sponge bath two times a week.

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

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

Residents were not provided with incontinence care in a timely manner.

#### FINDINGS #2:

During the investigation 18 resident records were reviewed, observations were conducted, and residents were interviewed.

The records of 18 residents were reviewed for quality of care concerns. There were no concerns identified related to incontinence care.

Eighteen residents, including seven residents who were cognitively impaired, were observed for quality of care. Residents were observed receiving incontinence care at different halls of the facility and there were no concerns identified regarding inappropriate care of those with incontinence. There were no offensive odors noted during the observations.

Residents who were cognitively intact were interviewed regarding incontinence care and none expressed concerns related to being left in soiled incontinence briefs for an extended period of time. Twelve residents attended a group interview and none expressed concerns regarding the quality of care they received from the facility staff.

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

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #3:

Residents did not receive oral care and a resident developed mouth sores and an infection.

#### FINDINGS #3:

The records of 20 residents were reviewed for quality of care concerns and residents and family were interviewed. Resident Council meeting minutes and facility grievances were also reviewed.

There were no grievances to the facility or documentation in the Resident Council minutes related to concerns about oral hygiene not being provided.

Residents wearing dentures were interviewed regarding their dentures care and there were no concerns noted. Residents who were unable to clean their own dentures said the staff were cleaning their dentures for them. Two family representatives were interviewed and they had no concerns with the quality of care their residents receive in the facility.

One resident's record included a nursing note, dated 10/6/18, which documented the resident's tongue was observed to have a thick whitish substance. The resident's physician prescribed Nystatin four times a day for five days. Nystatin is a medication that fights infections caused by fungus. According to the Mayo Clinic website, accessed on 7/23/19, drugs such as antibiotics that disturb the natural balance of microorganisms in your body can increase your risk of oral thrush. The resident's record documented she was prescribed and received an antibiotic for a urinary tract infection two weeks prior to the nursing note documenting she had the oral infection.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Residents' wheelchairs were not clean.

FINDINGS #4:

The facility's grievances and Resident Council Meeting minutes were reviewed. Residents were interviewed and observations of equipment were conducted.

There were no reports of wheelchairs being dirty or not cleaned in the facility's grievances or in the Resident Council Meeting minutes.

Residents were individually interviewed and they said they had no concerns related to their wheelchairs not being cleaned. Twelve residents attended the group interview and none of the residents who were using wheelchairs expressed concern related to their wheelchairs not being cleaned.

Wheelchairs were observed in the facility and they were clean with no stains or residue.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The facility was unable to take residents to their appointments due to transportation issues.

FINDINGS #5:

Facility grievances were reviewed, Resident Council Meeting minutes were reviewed, residents were interviewed, and staff were interviewed.

The facility's grievances and Resident Council Meeting minutes did not include documentation of concerns related to residents' not being able to go to their appointments due to transportation issues.

Residents were interviewed individually and said the facility was providing transportation to and from their medical appointments. Twelve residents attended the group interview and none voiced concerns regarding transportation issues for their appointments.

The Transport Aide said she scheduled the residents' appointments. The Transport Aide said the facility's van could accommodate two residents in their wheelchair and one independent resident. The Transport Aide also stated the facility had a back-up transport company that helped in transporting residents to their appointments when they had multiple appointments in one day.

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

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #6:

Residents had weight loss and were not assisted with meals when needed.

#### FINDINGS #6:

During the investigation, 20 resident records were reviewed for nutrition, facility grievances were reviewed, Resident Council Meeting minutes were reviewed and observations of meals were conducted.

The facility's grievances did not include documentation of concerns related to dining assistance. Resident Council Meeting minutes did not include documentation of concerns related to residents' not receiving assistance with their meals and waiting in the dining room for extended periods.

Residents were interviewed and stated they received assistance with their meals when requested. Twelve residents attended a group interview and there were no concerns raised regarding not receiving assistance with their meals.

Meal observations were made during a dinner service and during a breakfast service on 6/3/19 and 6/5/19 respectively. Staff members were observed seated at a table with residents who required assistance with their meals.

One resident's record documented she had multiple refusals of her meals. The resident's family was informed of her decreased intake and meal refusals. The resident's record documented alternate food choices and high protein snacks were offered three times a day.

The record also documented the family's request for food choices was provided and family also offered to bring in food. Referrals to the dietitian, social services, and speech therapist were completed related to the resident's decreased intake of food and refusals. The resident's record included documentation their physician was informed and the resident's medication was reviewed and she was prescribed an appetite stimulant.

The allegation regarding weight loss was substantiated, but based on the investigative findings the facility was not cited because no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

Staff are unsafe when using the Hoyer lift (mechanical lift) to transfer residents.

FINDINGS #7:

During the investigation, observations were conducted of residents being transferred with a Hoyer lift and residents were interviewed.

One male resident who had moderate cognitive impairment was observed being transferred to his bed. One CNA was behind the resident and another CNA was operating the Hoyer machine. The resident was transferred slowly and safely from his wheelchair to his bed. The resident did not show signs of fear or feeling unsafe when he was being transferred.

Another resident, a female resident who had severe cognitive impairment was observed as she was being transferred from her wheelchair to her bed using the Hoyer lift. There was no concern identified during the transfer. The female resident looked comfortable while being transferred.

Two residents, who were cognitively intact, who required the use of a Hoyer lift when being transferred said they felt safe and secure using the Hoyer lift and they had no concerns.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

Residents had skin breakdown and unidentified bruises.

FINDINGS #8:

During the investigation, 18 resident records were reviewed, residents and family members were interviewed, facility Incident & Accident reports were reviewed and staff were interviewed.

Residents were interviewed and said they received appropriate care to prevent skin breakdown.

An Incident & Accident report, dated 8/1/18, documented one resident had a dark red purple bruise on her lateral arm and also a dark purple bruise on her left lower shin. The Director of Nursing (DON) was interviewed and said the resident had very sensitive skin, was independent using her wheelchair during that time and able to reposition herself. The DON said the resident's bruises may have occurred when she was being transferred to/from a bed/wheelchair. The DON said the resident was provided with arm protector sleeves, and they ordered an arm protector with more padding for the resident. The DON also said staff were directed to place a pillow under the resident's left arm when she was sitting in the lounge chair.

The resident's record documented she was admitted to the hospital on 10/8/18 through 10/22/18. The resident's hospital report dated 10/22/18, documented she had sloughing (shedding) of the skin on her back, buttocks and posterior thighs which was attributed to an allergy with the antibiotic Vancomycin. The facility documented in the record the resident was at high risk for skin breakdown and she was provided with mineral oil applied on her skin 2-3 times each day and her skin was monitored each shift. The record documented staff were to inform the resident's physician for signs and symptoms of skin infection, further skin breakdown or failure to heal.

One family representative of a resident who was currently in the facility was interviewed and said the resident developed a small pressure ulcer on her thumb and it was now healed. The family representative said the resident wore a splint for the resident's contractures on her left hand. The family representative said he did not have concerns with the care.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Corwin Lewis, Jr., Administrator  
July 23, 2019  
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As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Laura Thompson", is positioned above the typed name.

Laura Thompson, RN, Supervisor  
Long Term Care Program

LT/lj