



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
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

July 22, 2019

Chase Gunderson, Administrator
Meadow View Nursing And Rehabilitation
46 North Midland Boulevard
Nampa, ID 83651

Provider #: 135076

Dear Mr. Gunderson:

On **July 11, 2019**, a survey was conducted at Meadow View Nursing And Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

Chase Gunderson, Administrator
July 19, 2019
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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 31, 2019**. Failure to submit an acceptable PoC by **July 31, 2019**, may result in the imposition of penalties by **August 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 **August 15, 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 **October 10, 2019**. A change in the seriousness of the deficiencies on **August 25, 2019**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **October 10, 2019** includes the following:

Denial of payment for new admissions effective **October 10, 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 **January 11, 2020**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **October 10, 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:

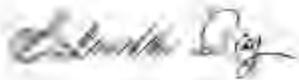
- BFS Letters (06/30/11)

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

This request must be received by **July 31, 2019**. If your request for informal dispute resolution is received after **July 31, 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: 08/08/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135076	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2019
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NAME OF PROVIDER OR SUPPLIER MEADOW VIEW NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651
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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	INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint survey conducted July 8, 2019 to July 11, 2019. The surveyors conducting the survey were: Jenny Walker, RN, Team Coordinator Presie Billington, RN Sharon Dunn, RD Abbreviations: DON - Director of Nursing MDS - Minimum Data Set RSD - Resident Services Designee	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 578		8/12/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 08/01/2019
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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	<p>Continued From page 1</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure residents received information and assistance to exercise their rights to formulate an Advance Directive. This was true for 2 of 6 residents (#7 and #8) 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:</p> <p>Resident #7 and Resident #8 did not have a copy of an Advance Directive in their record and their records did not include documentation an Advance Directive was discussed with them. The records for Resident #7 and Resident #8 also did</p>	F 578	<p>F 578</p> <p>Corrective action for residents found to have been affected by this deficiency- Resident #7 and #8 where interviewed and offered by social services and given the opportunity to formulate an advanced directive.</p> <p>Corrective action for residents that may be affected by this deficiency- All residents have the potential of being affected by this deficient practice. The facility conducted an audit of current residents to determine that an advanced directive has been offered, or is in place and has been scanned into the medical</p>		

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F 578	<p>Continued From page 2</p> <p>not include documentation they were provided assistance to formulate an Advance Directive.</p> <p>On 7/10/19 at 3:53 PM, the RSD said she discussed creating Advance Directives with residents upon admission and reviewed Advance Directives annually with the residents.</p> <p>On 7/11/19 at 11:26 AM, the RSD said she did not find documentation an Advance Directive was discussed with Resident #7 or Resident #8.</p>	F 578	<p>record.</p> <p>Measures that will be put in place to ensure that this deficiency does not reoccur-DON, SDC, or designee with educate the IDT, social services staff, and business office staff on the requirement to offer to all residents who admit to this facility the information on an advanced directive that follows state recommendations as well as the option to have facility assistance to formulate an advanced directive if the resident expresses interest. Education to staff will also include; to discuss advanced directives with the resident quarterly during care plan conferences or MDS quarterly reviews to review for changes in residents wishes. Education completed by August 09, 2019</p> <p>Measures that will be implemented to monitor that he continued effectiveness of the corrective action taken to ensure that this deficiency has been correct and will not reoccur-The DON or designee will audit on a weekly basis for 8 weeks, of any new resident who enters the facility to ensure that; education on advanced directives is being offered upon admission, as well as the offer to formulate an advanced directive at the time of admission. If during the admission process an advanced directive is available the business office person will obtain a copy and place it in the medical record. Residents who are interested in completing an advanced directive will be</p>		

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F 578	Continued From page 3	F 578	advised that social services will assist them in completing this process. Those who decline will be reoffered quarterly of the option to formulate an advanced directive if they desire to. IDT will audit weekly for 12 weeks, reviewing quarterly care conference assessments to ensure that advanced directives are in place, being offered, or discussed in these care conferences. The ED or DON will review and report the results of the audits monthly in QA committee meeting for 3 months, any recommendations from review of the findings in QA will be implemented if indicated. Corrective action completed by August 12, 2019		
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. §483.10(j)(3) The facility must make information	F 585		8/12/19	

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F 585	Continued From page 4 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 coordinating with state and federal agencies as	F 585			

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F 585	Continued From page 5 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 resident and staff interview, policy review, record review, and review of grievances,	F 585	F585 Corrective action for residents found to		

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F 585	<p>Continued From page 6</p> <p>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 18 residents (Resident #79) reviewed for grievances. This failure created the potential for psychosocial harm if resident grievances were not acted upon. Findings include:</p> <p>The facility's Grievance policy, revised 11/2017, documented the Grievance Official responded to an individual who expressed a concern within 3 working days, and contacted all parties with the outcome of the investigation.</p> <p>Resident #79 was admitted to the facility on 2/15/18 and readmitted on 3/11/19, with multiple diagnoses including diabetes mellitus.</p> <p>Resident #79's quarterly MDS assessment, dated 6/21/19, documented she was cognitively intact.</p> <p>On 7/8/19 at 1:57 PM, Resident #79 said she was missing two rings, a necklace, and one set of earrings since 12/2018. She said the missing jewelry was a gift from her son last Christmas. Resident #79 said she filed a grievance about the missing jewelry and had not heard about it.</p> <p>The facility's grievance file from 12/2018 through 7/2019 was reviewed. There was no grievance for Resident #79 regarding her missing jewelry.</p> <p>On 7/10/19 at 1:40 PM, the RSD said she was the Grievance Official and she remembered the grievance about Resident #79's missing jewelry. The RSD said Resident #79 told her the missing jewelry was irreplaceable because it was a gift</p>	F 585	<p>have been affected by this deficiency-Administration and social services met and discussed the grievance with Resident #79. Receipts were obtained from the family and the money has been reimbursed to the family.</p> <p>Corrective action for residents that may be affected by this deficiency-All residents have the potential to be affected by this deficient practice. An audit was completed to assess for any pending grievances. No pending grievances at this time.</p> <p>Measures that will be put in place to ensure that this deficiency does not reoccur-DON, SDC or designee will educate the IDT and social services on the facility policy regarding grievances, specifying in the education the notification of the appropriate parties (grievance officer and designee) and the turnaround time for completion of the grievance. Education will be completed by August 09, 2019</p> <p>Measure that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not reoccur-Social services will be given a designee who will assist in the grievance process. This individual will help ensure that the grievance is recorded, reported, and will as well verify that a resolution is in place for the submitted grievance. The DON or designee will audit weekly for 12</p>		

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F 585	Continued From page 7 from her son last Christmas. The RSD said they searched Resident #79's room but did not find the jewelry. The RSD stated she contacted Resident #79's son and asked him to provide the receipt for the jewelry. The RSD said Resident #79's son told her not to worry about repaying him for the missing jewelry. The RSD said she remembered talking to Resident #79 about her conversation with her son. The RSD was unable to provide documentation of her investigation, resolution, or outcome regarding Resident #79's missing jewelry.	F 585	weeks to ensure that all grievances have been; reported and will also verify that a resolution is in place. The ED or DON will review and report the results of the audits monthly in QA meeting for 3 months. Any recommendation from review of the findings in QA will be implemented if indicated. Corrective action completed by August 12, 2019		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. 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 fall prevention was implemented as care planned. This was true for 1 of 5 residents (Resident #44) reviewed for falls. This failure had the potential for harm if residents sustained bone fractures or other serious injuries from falls. Findings include: The facility's policy for Fall Prevention, revised 5/2018, documented the facility investigated the circumstances surrounding each resident fall and	F 689	F 689 Corrective action for residents found to have been affected by this deficiency-Resident # 44's care plan was reviewed for accuracy, it was verified that the floor mat is listed under the intervention list in the "at risk for falls" portion of her care plan. The floor mat was visualized on the floor in resident #44's room and was noted to be in the appropriate place.	8/12/19	

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F 689	<p>Continued From page 8</p> <p>implemented actions to reduce the incidence of additional falls and minimized the potential for injury.</p> <p>Resident #44 was admitted to the facility on 8/31/17, and was readmitted on 9/22/18, with multiple diagnoses including muscle weakness, dementia and diabetes mellitus.</p> <p>A quarterly MDS assessment, dated 5/17/19, documented Resident #44 had moderate cognitive impairment, required extensive assistance of one staff member for bed mobility, transfers, locomotion, dressing, toilet use and personal hygiene. The assessment also documented Resident #44 was not steady and required staff assistance to stabilize her when moving from a seated to a standing position and on and off the toilet. Resident #44 used a walker or a wheelchair for mobility.</p> <p>A nursing progress note, dated 2/27/19 at 11:20 PM, documented Resident #44 was found on the floor next to her bed. The note documented Resident #44 stated she was trying to catch bugs and fell.</p> <p>A Fall care plan, revised 3/11/19, documented Resident #44 was at risk for falls. The care plan goal was for Resident #44 not to sustain a serious injury through the next care plan review. Interventions included in Resident #44's care plan, dated 9/25/18, documented staff were to place a floor mat beside her bed.</p> <p>A nursing progress note, dated 5/15/19 at 2:30 AM, documented Resident #44 slid down to the floor and landed on her buttocks when she</p>	F 689	<p>Corrective action that may be affected by this deficiency-All residents have the potential to be affected by this deficient practice. The facility conducted an audit of current residents in the facility with floor mats to determine tat the specific intervention listed in the care plan was in place for each resident.</p> <p>Measures that will be put in place to ensure that this deficiency does not reoccur-DON, SDC or designee will educate, therapy, nursing, and house keeping staff on floor mats that includes; that therapy and nursing staff will notify the IDT if adding or removing a floor mat for fall prevention from the resident care plan, so as to allow for an update of the care plan to ensure accuracy. House keeping has been educated to immediately clean or replace a soiled floor mat as specified per the residents plan of care.</p> <p>Education completed by August 09, 2019</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not reoccur-The DON or designee will audit weekly for 12 weeks to ensure that all care planned floor mats are in place, and in the appropriate locations. The ED or DON will review and report the results of the audits monthly in QA committee meeting for 3 months. Any recommendations from review of the findings in QA will be implemented if</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135076	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2019
NAME OF PROVIDER OR SUPPLIER MEADOW VIEW NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651		
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F 689	<p>Continued From page 9</p> <p>self-transferred from her bed to her wheelchair. The note documented Resident #44 stated she was getting up to go to the restroom. Resident #44 was noted to have an approximately 3 centimeter (cm) x 3 cm skin tear on her right great toe.</p> <p>A nursing progress note, dated 5/25/19 at 5:14 AM, documented Resident #44 had a fall when she attempted to self-transfer from her bed to her wheelchair.</p> <p>A nursing progress note, dated 7/5/19 at 11:43 PM, documented Resident #44 was observed on the floor in her room in front of her roommate's bed. Resident #44 was noted to have a hematoma above her right eyebrow.</p> <p>A Fall Risk Assessment, dated 7/6/19, documented Resident #44 had 1-2 falls in the past 3 months and was at high risk for falls. The Fall Assessment also documented Resident #44 required assistance with elimination and required an assistive device for ambulation.</p> <p>On 7/8/19 at 3:27 PM, 7/9/19 at 9:30 AM, 11:26 AM, 2:50 PM, 7/10/19 at 9:16 AM, 10:02 AM and 1:42 PM and on 7/11/19 at 9:44 AM, Resident #44 was observed in bed without the floor mat in place.</p> <p>On 7/11/19, at 9:28 AM, Resident #44's medical record was reviewed with the DON. The DON said Resident #44 had a history of falls and had a care plan intervention to have a floor mat in place next to her bed.</p> <p>On 7/11/19 at 9:49 AM, the surveyor and DON,</p>	F 689	<p>indicated.</p> <p>Corrective action completed by August 12, 2019</p>		

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

PRINTED: 08/08/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135076	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2019
NAME OF PROVIDER OR SUPPLIER MEADOW VIEW NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651		
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F 689	Continued From page 10 observed Resident #44 in bed without a floor mat next to her bed. The DON verified Resident #44 did not have a floor mat beside her bed in accordance with her plan of care.	F 689			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001480	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2019
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NAME OF PROVIDER OR SUPPLIER MEADOW VIEW NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651
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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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the state licensure survey conducted July 8, 2019 to July 11, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Presie Billington, RN Sharon Dunn, RD</p>	C 000		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure committee members participated in Infection Control Meetings. This failure has the potential to affect all residents, staff and visitors to the facility. Findings include:</p> <p>On 7/11/19 at 9:32 AM, the Infection Control Nurse (ICN) said the facility conducted monthly Infection Control meetings.</p> <p>Infection Control Committee attendance records, dated 8/29/18, 9/26/18, 10/31/18, 11/28/18, 1/27/19, 3/27/19, 4/24/19, 5/29/19 and 6/26/19, documented:</p> <p>* A representative from Dietary did not participate in November, January, March, April and May meetings which covers the last two quarters.</p>	C 664	<p>C 664 Corrective action for facility process found to have been affected by this deficiency-The infection control sign in sheet has been updated with a list of titles of all members of the QA committee who are required to participate in this meeting.</p> <p>Measures that will be put in place to ensure that this deficiency does not reoccur-Administrator will be responsible for inviting all members to the infection control meeting. The administrator will review and obtain signatures of the required attendees each month to ensure that compliance is maintained. DON, SDC or designee will educate the members of the QA committee on the requirement to attend the monthly</p>	8/12/19

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 08/01/19
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001480	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2019
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C 664	Continued From page 1 The ICN said she did not know why representative from Dietary department did not participate in the last two quarterly meetings.	C 664	infection control committee meeting. Education completed by August 09, 2019 Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not reoccur-The ED or designee will review the infection control sign in sheet monthly for 3 months to ensure that compliance is met. The ED or DON will review and report the results of the audit monthly in QA meeting. Any recommendations from the review of the finding in QA will be implemented if indicated. Corrective action completed by August 12, 2019	
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IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
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FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

August 2, 2019

Chase Gunderson, Administrator
Meadow View Nursing and Rehabilitation
46 North Midland Boulevard
Nampa, ID 83651

Provider #: 135076

Dear Mr. Gunderson:

On **July 8, 2019** through **July 11, 2019**, an unannounced recertification and complaint survey was conducted at Meadow View Nursing And Rehabilitation. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007820

ALLEGATION #1:

Residents developing pressure ulcers in the facility.

FINDINGS #1:

During the survey eighteen resident records were reviewed, observations were conducted, facility incident and accident reports were reviewed and staff were interviewed.

Observations were conducted during the survey for quality of care and infection control protocols. The facility's incident and accident reports were reviewed

Two residents records were reviewed for pressure ulcers. One resident's record, documented she was admitted January 2018. The resident's record documented weekly skin assessments were completed by the licensed nurse and no concerns were identified.

The resident's record documented at the end of February 2018, she had a hard lump and the skin was intact to the left buttocks. The resident's record documented she had a history of cysts in the past and the lump felt like the previous cysts. The resident's record documented she was referred to a local wound clinic and the wound clinic physician documented the area as a sebaceous cyst. The resident's record documented she was discharged home with home health services and to follow up with the wound clinic. The resident's record did not document the resident had a pressure ulcer.

The Director of Nursing stated the resident was admitted to the facility for aftercare post hip surgery and stated the resident was mobile and did not acquire a pressure ulcer while the resident resided in the facility.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility was not providing cares to residents who were incontinent.

FINDINGS #2:

Five out of six residents were observed for incontinent care provided by the staff. During the survey, the facility did not have odors and the residents had no concerns with incontinent care.

One of the six resident's record documented the resident was incontinent and the staff provided incontinent care per the resident's care plan.

Two CNAs were observed providing incontinent care to a resident appropriately. The CNAs changed the resident's brief, provided peri care, and replaced with a clean brief for a resident. The CNAs stated they check and change residents based on the resident's personalized care plan need. The Director of Nursing stated the facility provides incontinent care to residents' every two hours and as needed.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility staff were not careful while transferring residents.

FINDINGS #3:

Five out of five residents' records were reviewed for injury related to transfers by the staff. One of the five resident's record was reviewed for an injury caused by transfers and no concerns were identified. The resident's record documented weekly skin assessments with no noted bruises identified.

CNAs were observed transferring five residents with two staff members with a pivot transfer and with transfers using a mechanical lift. The CNAs appropriately transferred the residents' without hitting their extremities on a table or other equipment to cause a bruise.

The Director of Nursing and the Assistant Director of Nursing stated they spot check staff to assure they are properly transferring residents and not causing an injury.

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

ALLEGATION #4:

The facility had an outbreak of pneumonia and the residents were being treated with Tamiflu.

FINDINGS #4:

The Infection Control Nurse stated the facility had an outbreak of the flu the end of February 2018 to beginning of March 2018. The Infection Control Nurse stated there were five residents who tested positive for the flu and were treated. The Infection Control Nurse stated the physician prescribed Tamiflu to all the residents who were showing signs and symptoms of the flu. The Infection Control Nurse stated the local health department was notified of the outbreak and followed infection control guidelines per the CDC (Centers for Disease Control).

One of the five resident's records documented the resident was having signs and symptoms of the flu. The resident's record documented the physician prescribed Tamiflu for the resident.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Chase Gunderson, Administrator
August 2, 2019
Page 4 of 4

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

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

Sincerely,

A handwritten signature in cursive script that reads "Belinda Day".

Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN – Director

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July 17, 2019

Chase Gunderson, Administrator
Meadow View Nursing and Rehabilitation
46 North Midland Boulevard
Nampa, ID 83651

Provider #: 135076

Dear Mr. Gunderson:

On **July 10, 2019** through **July 11, 2019**, an unannounced on-site complaint survey was conducted at Meadow View Nursing and Rehabilitation. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008147

ALLEGATION #1:

The facility failed to ensure residents' activities of daily living (ADL) were met.

FINDINGS #1:

During the investigation, records of 18 residents and two closed records were reviewed for quality of care and quality of life concerns. The facility's Grievance file and Resident Council minutes from January 2019 to July 2019 were also reviewed. There were no grievances in the Grievance file or concerns in the Resident Council minutes related to residents not being assisted by the staff with their activities of daily living.

During the initial tour of the facility observations were conducted. Residents' rooms were clean and their beds made. Four residents observed were attended by staff with their needs. One staff member was observed repositioning a resident and provided the resident with water to drink. Staff interactions with the residents were observed and there were no concerns identified. Dining observations were completed on 7/8/19, in the facility's Special Care Unit dining room and in the Big Band dining room. Residents were groomed, hair combed, and their clothes looked clean. Staff were interacting appropriately with the residents, and helped residents who needed assistance with their meals.

Residents were observed playing bingo in the Big Band dining room. Residents were groomed, hair combed, and their clothes looked clean. All of the residents playing bingo appeared to enjoy the game and participated.

Residents were observed in different areas of the facility during the survey week, and no concerns were identified regarding their grooming. Incontinence care was provided in a timely manner. There were no unpleasant odors noted in the facility.

Ten residents attended a group interview and no concerns were voiced about the care they received at the facility.

Three family representatives were interviewed and no concerns were voiced about the care their family member received in the facility.

Fifteen residents were interviewed individually including one quadriplegic resident. There were no concerns expressed related to their ADLs. The residents reported the staff were assisting them with their oral care, grooming and they received their baths/showers twice a week. The resident who was a quadriplegic said he was repositioned by the staff and they assisted him with his transfers to/from bed/wheelchair when he asked.

The Ombudsman said he talked to one resident and the resident said she did not feel in danger in the facility. The resident said she had concerns with the number of staff available to meet the residents' needs.

Staff members were interviewed and said they were able to complete their tasks and meet the residents' needs during their shift.

One resident's medical record documented she required the assistance of one staff member for her ADLs. Throughout the survey week the resident was observed as well groomed, with her hair combed, clean clothes, and her teeth were discolored but otherwise clean. The resident was able to feed herself and could propel her wheelchair. The resident was observed putting a jigsaw puzzle together by herself and played bingo with other residents.

One resident was interviewed and said she felt safe in the facility. The resident said there was a Certified Nursing Assistant (CNA) working in her hall who looked like a teenager and she felt like the CNA did not take care of her the way she should.

When asked if the CNA met her needs, the resident said "yes." The resident said the staff were assisting her with her ADLs. The resident's shower/bath record, dated 6/12/19 through 7/10/19, documented she received her shower/bath twice a week.

Based on the investigative findings, the allegation could not be substantiated, and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility failed to ensure medications were administered as prescribed.

FINDINGS #2:

The facility's Grievance file and Resident Council minutes from January 2019 to July 2019 were reviewed. There were no grievances in the Grievance file or concerns in the Resident Council minutes related to the residents' medications not being administered.

Ten residents attended the group interview, and there were no concerns voiced regarding their medications not being administered as ordered.

Fifteen residents were interviewed individually, and no concerns were voiced regarding their medications not being administered as ordered.

One resident's Medication Administration Record, dated 5/1/19 through 7/11/19, documented her medications were administered as ordered.

Based on the investigative findings, the allegation could not be substantiated and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Chase Gunderson, Administrator
July 17, 2019
Page 4 of 4

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

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

Sincerely,

A handwritten signature in cursive script that reads "Belinda Day". The signature is written in black ink and is positioned above the typed name and title.

Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj