



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

September 15, 2020

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

Provider #: 135076

Dear Mr. Gunderson:

On **August 28, 2020**, 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.

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 **September 25, 2020**. Failure to submit an acceptable PoC by **September 25, 2020**, may result in the imposition of penalties by **October 18, 2020**.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **October 2, 2020 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **November 18, 2020**. A change in the seriousness of the deficiencies on **October 12, 2020**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **November 18, 2020** includes the following:

Denial of payment for new admissions effective **November 18, 2020**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 18, 2021**, 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 **November 18, 2020** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **September 25, 2020**. If your request for informal dispute resolution is received after **September 25, 2020**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

bd/lh

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

PRINTED: 09/28/2020
FORM APPROVED
OMB NO. 0938-0391

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|---|--|---|---|----------------------|---|
| 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 C 08/28/2020 |
| NAME OF PROVIDER OR SUPPLIER MEADOW VIEW NURSING AND REHABILITATION | | | STREET ADDRESS, CITY, STATE, ZIP CODE 46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651 | | |
| (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 A Complaint Survey was conducted at the facility from August 26, 2020 to August 28, 2020. The surveyors conducting the investigation were: Presie C. Billington, RN, Team Coordinator Kimberly Saccomando, RN Abbreviations: DON = Director of Nursing POA = Power of Attorney | F 000 | | | |
| F 584 SS=D | Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, | F 584 | | 9/28/20 | |

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

TITLE

(X6) DATE

Electronically Signed

09/21/2020

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

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| F 584 | <p>Continued From page 1 and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to exercise reasonable care for the protection of a resident's property from loss or theft. This was true for 1 of 3 residents (Resident #4) whose closed records were reviewed. This failure created the potential for diminished quality of life and distress due to belongings being taken from a resident's possession. Findings include:</p> <p>Resident #4 was discharged from the facility on 8/18/20. A nursing progress note, dated 8/24/20, documented a woman who identified herself as Resident #4's daughter was given all of Resident #4's belongings in the facility and left the facility with them.</p> <p>Resident #4's record did not include the individual's name who took Resident #4's</p> | F 584 | <p>F 584</p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>All residents have the potential of being affected by this deficient practice.</p> <p>Corrective action for residents that may be affected by this deficiency:</p> <p>The licensed nurse who mistakenly gave the belongings of a discharged resident to a family member who was not approved to receive items, was educated on the error and the correct protocol was explained.</p> <p>Measures that will be put into place to</p> | | |

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| F 584 | <p>Continued From page 2</p> <p>belongings on her emergency contact list.</p> <p>A Social Services note, dated 8/25/20, documented Resident #4's POA was called and notified Resident #4's belongings were given to someone not on the emergency contact list.</p> <p>On 8/26/20 at 7:53 PM, the Administrator stated when a resident left the facility, or passed away, the POA or emergency contact was notified and a plan on how to remove belongings from the facility was initiated and acted upon by staff and family.</p> <p>On 8/26/20 at 8:25 PM, the DON stated when family showed up for resident belongings, staff gave them to the family member because they knew them. He stated the facility policy was to give all the belongings to the POA if the resident had one, or individuals listed as emergency contacts. The DON stated belongings should not have been given to anyone other than POA or an individual listed as an identified emergency contact.</p> <p>On 8/27/20 at 3:22 PM, Social Services Employee #1 stated facility policy was to call the POA at discharge to request what to do with a resident's belongings. She stated the facility did not release Resident #4's belongings to the POA, or an emergency contact.</p> | F 584 | <p>ensure that this deficiency does not recur:</p> <p>Individuals that may be requested to hand over personal items to family members will be educated to; inquire the name of the person picking up requested items as to verify that the individual's name is on the list of contacts in the residents chart who are allowed to receive a residents personal items.</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 recur:</p> <p>DON, SDC or designee will provide an in-service with individuals who would come in contact with or receive requests for personal items from family members. These individuals include the nursing team, social services group, business office personnel, and the lobby staff. The facility protocol will be for the individual to check the chart of the resident whose items are being requested and ensure that the name of the individual is on the residents profile/contact list. The contact list signifies that these individuals may pick up residents items.</p> <p>Corrective action completed by:</p> <p>In-service will be completed by September 28th, 2020</p> <p>Audits will begin September 21st, 2020 and will continue for 8 weeks. Audits will</p> | | |

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| F 584 | Continued From page 3 | F 584 | <p>be performed by the social services group. DON or designee will review each week for completion. Social services will discuss with families during care conferences to make sure that the contact list is complete, and that the individuals on the contact list are allowed to take items out of the facility for the specific resident.</p> <p>Results of the audits will be reported on monthly in QA.</p> | | |