STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135068	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parke View Rehabilitation & Care Center	2303 Parke Avenue Burley, ID 83318

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents who self-administer medications had been assessed and evaluated for cognitive and physical ability to self-administer medications and reviewed by the Interdisciplinary Team (IDT) prior to residents self-administering medications for two of two residents (Resident (R) 38 and R11) observed self-administering medications. As a result of this deficient practice, medications may or may not actually be correctly administered. Findings below: 1. Review of R38's Admission Record located in the electronic medical record (EMR) under the Profile tab revealed an admitted [DATE] and readmission on 12/20/21 with medical diagnosis including cerebral infarction. Review of R38's quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 06/16/24, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating R38 was cognitively intact. Observation on 08/19/24 at 12:10 PM, R38 was sitting on the side of the bed and two pills were in a clear medication cup, a big white one and small red one. The resident said, these are the pills I take with lunch. During an interview on 08/19/24 at 12:34 PM, Licensed Practical Nurse (LPN) 1 explained the resident does not like to be rushed when taking medications and when LPN 1 entered the resident room to administer the medication, the resident was being assisted in the bathroom and requested that LPN 1 left the pills on the bedside table. LPN1 confirmed the medications were iron and sodium chloride supplements. Review of R38 EMR under the Assessments tab lacked documentation of an assessment for self-administration of medications. Review of R38's physician orders in the EMR under the Orders tab documented an order for: Ferrous Sulfate Tablet 325 milligrams (mg) Give 1 tablet by mouth one time a day every Mon, Wed, Fri for supplement and Sodium Chloride Tablet 1 gram Give 1 tablet by mouth three times a day for electrolyte supplement WITH MEALS and lacked an order for self-administration of medications. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R38's Care Plan under the Care Plan tab in the EMR lacked documentation for self-administration of medications. 2. Review of R11's Admission Record located in the EMR under the Profile tab, revealed and admitted [DATE] and readmission on 12/01/21 with medical diagnosis including dementia with other behavioral disturbances. Review of R11's quarterly MDS located in the EMR under the MDS tab with an ARD of 06/20/24, revealed a BIMS score of three out of 15, indicating R11 was severely cognitively impaired. Observation in the main dining rooms on 08/21/24 at 08:32 AM, R11 was sitting at the table waiting for the meal tray. On the napkin there were five pills covered by an upside-down clear medication cup. During an interview on 08/21/24 at 8:41 AM, LPN 2 confirmed the mediations under the medication cup were Metformin two tablets, Finasteride one tablet, Lisinopril one tablet, and Eliquis one tablet. LPN2 explained R11 wanted to take his pills with food so LPN2 gave him his pills in the medication cup and R11 placed them in his pocket on his way to the dining room so R11 could take the medications with breakfast. Review of R11's EMR under the Assessments tab lacked documentation of an assessment for self-administration of medications. Review of R11's physician orders under the Orders tab documented Eliquis Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day for atrial fibrillation, Finasteride Tablet 5 MG Give 1 tablet by mouth one time a day for BPH, Lisinopril Oral Tablet 2.5 MG (Lisinopril) Give 2.5 mg by mouth one time a day for HTN [hypertension], and metformin HCl ER Tablet Extended Release 24 Hour 500 MG Give 2 tablet by mouth in the morning for DM II [diabetes mellitus] and lacked an order for self-administration of medications. Review of R11's Care Plan under the Care Plan tab in the EMR lacked documentation for self-administration of medications. During an interview on 08/20/24 at 12:50 PM the Director of Nursing (DON) and the Clinical Resource Nurse confirmed the process for a resident to self-administer medications included completing a self-administration assessment located in the Assessments tab in the EMR and an assessment done by the IDT team. During an interview on 08/21/24 at 12:10 PM, the DON confirmed the nurse administering the resident mediation was to observe the medication being administered prior to documenting the medication being administered. The DON confirmed R11 and R38 had not been assessed for self-administration of medications, the IDT process had not been involved and the medications should not have been left with the residents to be self-administered (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Self-Administration of Medications revised 5/22, revealed The residents cognitive, communication, visual, and physical ability to carry out this responsibility will be evaluated. If the interdisciplinary team determines that this resident is unable to carry out this responsibility (this would be dangerous to resident or others), the interdisciplinary team may withdrawal this right. Appropriate notation of these determinations will be placed in the residents care plan.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on record review, staff interview and policy review, the facility failed to ensure that a Preadmission Screening and Resident Review (PASARR) level I assessment was completed after the resident remained in the facility past the initial 30 day exception for one residents (Resident (R)31 out of one residents out of a total sample of 22 residents reviewed for PASARR level I screenings which had the potential to prevent or delay additional services to a resident that may qualify for a level II. Findings include: 1. Review of R31's undated Face sheet, located in the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, major depressive disorder, anxiety disorder, and post-traumatic stress disorder. Review of R31's admission Minimum Data Set (MDS) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 07/01/24, revealed a Brief Interview for Mental Status (BIMS), score of 15 out of 15 which indicated R31's cognition was intact. Further review the MDS indicated an active diagnosis of schizophrenia, post-traumatic stress disorder (PTSD), anxiety disorder and major depressive disorder. Review of R31's Abbreviated Level II Preadmission Screening for Nursing Home Placement (PASARR) located under the Resident Documents tab in the EMR and dated and submitted on 06/29/24 indicated admission meets criteria for Hospital Exception and meets all the following and has a known or suspected Mental Illness (MI) diagnosis. The attending physician has certified prior to nursing facility (NF) admission the resident will require less than 30 calendar days of NF services. Further review revealed individuals meeting criteria are exempt from Level II screens. But the facility must complete a PASARR at such time that it appears the individuals stay will exceed 30 days and no later than the 40th calendar day. During an interview on 08/21/24 at 10:04 AM, Medical Records (MR) stated the hospital completed the initial PASARR and she would check to see if they had a 30-day exemption, and she kept a log of those that helped her know when a new PASARR needed to be completed if they remained in the facility past 30 days. MR stated that she missed completing R31's PASARR level 1 and confirmed R31 had been in the facility almost two months. During an interview on 08/22/24 at 9:20 AM, the Director of Nursing (DON) said she was unaware that a new Level I was not completed for R31 and sent in after the resident was in the facility past 30 days. Review of the facility's undated policy titled Preadmission Screening for MI/MR [Mental Retardation] revealed, It is the policy if the facility to ensure that each resident is properly screened using the PASARR specified by the state.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on observation, interview, record review, and Fundamentals of Nursing textbook guidance, the facility failed to ensure a physician's order was in place prior to flushing a Foley catheter for one of three residents (Resident (R) 49) reviewed for indwelling urinary catheter care. As a result of this deficient practice there is a potential for introducing bacteria into the closed indwelling urinary catheter system. Findings include: Review of R49's Admission Record located in the electronic medical record (EMR) under the Profile tab, revealed an admitted [DATE] and readmission on 01/26/24 with medical diagnosis including obstructive and reflux uropathy [ureteral obstruction-urine flows from bladder backwards to ureter]. Review of R49's quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 06/08/24, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating R49 was cognitively intact. Observation on 08/19/24 at 12:18 PM, R49 was in the wheelchair, sitting in the 500-hall dining room awaiting lunch. The indwelling urinary catheter tubing was visible and the urine was slightly blood tinged. Review of R49's Prog Notes in the EMR revealed a note created by LPN1 on 08/20/24 at 06:13 AM, documented Resident came back from his U/S [ultrasound] and had slight pink tinged urine. Pt [patient] was assessed. The catheter was assessed and flushed. Pt didn't have any c/o [complaint of] pain or discomfort. no burning or redness. nurse will monitor for continued change to urine color. Review of R49's physician orders in the EMR under the orders tab lacked documentation of an order to flush the indwelling urinary catheter. Review of the standing orders for R49 lacked documentation of an order to flush the indwelling urinary catheter. During an interview on 08/20/24 at 12:50 PM, the Director of Nursing (DON) and the Clinical Resource Nurse verbalized the flushing of a Foley catheter required a physician's order and that LPN1 should not have flushed the indwelling urinary catheter without an order. During an interview on 08/21/24 at 12:36 PM, LPN1 stated that she thought there was a standing order for flushing an indwelling urinary catheter, however, she was in error, there was no standing order and should not have flushed the catheter. During an interview on 08/21/24 at 11:20 AM, the Assistant Director of Nursing (ADON) confirmed the nursing procedure reference for the facility was the Fundamentals of Nursing textbook by [NAME] and [NAME], sixth edition. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Fundamentals of Nursing textbook by [NAME] and [NAME], sixth edition, page 438 documented for flushing a closed and open catheter irrigation, indicated, to verify physician's order before performing the procedure.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on record review, interview, and facility policy review, the facility failed to ensure residents received alternative measures prior to installation of side rails, for two of three residents reviewed for side rails (Resident (R) 84 and (R) 26) of 22 sampled residents. The lack of alternative measures and proper assessment could lead to potential restraint or side rail entrapment. Findings include: Review of R84's undated Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed the resident was admitted on [DATE] with diagnoses included difficulty in walking and aftercare for joint replacement. Review of R84's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/26/24 revealed a Brief Interview for Mental Status (BIMS) score of three out of 14 which indicated the resident was severely cognitively impaired. Review of R84's Care Plan, initiated 07/23/24, located under the Care Plan tab of the EMR revealed at risk for falls with an intervention of side rails as ordered. Review of R84's Side Rail Assessment located under the Observations tab of the EMR, dated 08/16/24, revealed no documentation of alternative measures. Further review revealed only risk and benefits, and consent was obtained. 2. Review of R26's undated Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed the resident was admitted on [DATE] with diagnoses included lack of coordination, difficulty in waking, and unsteadiness on feet. Review of R26's admission MDS with an ARD of 07/11/24 revealed a BIMS score of three out of 15 which indicated the resident was severely cognitively impaired. Review of R26's Care Plan, initiated 07/09/24, located under the Care Plan tab of the EMR revealed at risk for falls with an intervention of side rails as ordered. Review of R26's Side Rail Assessment located under the Observations tab of the EMR, dated 08/16/24, revealed no documentation of alternative measures. Further review revealed only risk and benefits, and consent was obtained. During an interview on 08/21/24 at 7:57 AM, Licensed Practical Nurse (LPN)4 stated she completed the admission side rail assessment for both residents. She spoke with both residents about siderail use, went over the risks and answered the questions on the assessment. She stated that nursing identified if a resident needed side rails. She stated they don't look at alternative measures prior to implementing bedrails for a resident. She said she did not know they were supposed to. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/21/24 at 9:06 AM, Therapy Resource (TR) said therapy only signed off on the bedrail assessment after it was completed by nursing and was unsure if therapy completed their own. During an interview on 08/22/24 at 9:09 AM the Director of Nursing (DON) said during admission, nursing completed the bedrail assessment based on the resident's needs and how they were doing. They would determine if bed rails would assist the resident with getting in and out of bed or to reposition. They would review with the resident if they wanted or needed a bedrail and get consent from them or their responsible party. But she was unaware there needed to be documentation that prior alternatives were explored before implementing bed rails for a resident and that this was not completed. Review of the facility's policy titled Bed Rails revised 12/2023, revealed It is the policy of this facility to attempt to use appropriate alternatives prior to installing a side or bed rail.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on observation, interview, manufacturer's instruction review, and policy review, the facility failed to ensure expired mediations were discarded in one of two medication rooms (main medication room on TCU unit) reviewed for outdated medications. As a result of this deficient practice residents may receive medication with decreased potency and effectiveness. Findings include: During an observation on [DATE] at 10:31 AM, in the medication room for the TCU unit, two boxes of Bisacodyl suppositories were stored in the refrigerator with an outdate of ,d+[DATE]. The box that held the vial of Tuberculin Purified Protein Derivative (TB) (Tubersol) was dated on the box as opened on [DATE]. During an interview on [DATE] at 10:32 AM, Registered Nurse (RN)1 confirmed the suppositories were out of date and should not be used for residents. The TB box with the date of [DATE], was unable to explain when the opened vial expired. During an interview on [DATE] at 11:54 AM the Director of Nursing (DON) confirmed outdated medications are not to be administered and when outdated medications are found, they are to be discarded. Review of the manufacturer's instructions for Tuberculin Purified Protein Derivative (Tubersol revealed, a vial of TUBERSOL which has been entered and in use for 30 days should be discarded. Do not use after expiration date. Review of the facility policy titled Specific Medication Administration Procedures-Administration Procedures for all Medications, with an effective date of ,d+[DATE] revealed, Check expiration date on package/container before administering any medication. When opening a multidose container, place the date on the container.