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	08/21/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure dignity of residents when staff enter their rooms without knocking and waiting for acknowledgement to enter. This was true for 5 out of 6 resident rooms observed during afternoon CNA rounds. This deficient practice placed residents at risk of embarrassment and diminished sense of self-worth. Findings include:Resident #4 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including diabetes and heart failure.On 8/18/25 at 2:02 PM, observed CNA #1 walk into Resident #4's room without knocking and then he continued down the hall entering rooms 124, 125, 126, 127, and 130 without knocking.On 8/18/25 at 2:13 PM, CNA #1 stated he was late getting off shift and will remember to knock before entering next time. On 8/18/25 at 2:22 PM, the DON stated CNAs should always knock before entering a resident's room and had not.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure residents Minimum Data Set (MDS) had correct assessment information. This was true for 1 of 8 residents (Resident #8) reviewed for accuracy of MDS assessments. This deficient practice created the potential for residents to have their mental health needs not met due to inaccurate assessments. Findings include: Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including acute hepatitis C (the initial phase of hepatitis C virus (HCV) infection, typically lasting for the first six months after exposure) and alcoholic cirrhosis of the liver without ascites (a condition where the liver is scarred due to excessive alcohol consumption, but without the accumulation of fluid in the abdomen).Resident #8's had a new diagnosis of bipolar disorder added on 6/26/25. A significant change in status assessment had not been submitted to update Resident #8's MDS.On 8/19/25 at 2:35 PM, the facility social services staff #1 stated Resident #8's MDS had not been updated when he received the bipolar disorder diagnosis and should have been.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, Idaho Medicaid Plan Benefit 16.03.26.475.03, observation, and staff interview, it was determined the facility failed to update a residents' Level I PASRR (Preadmission Screening and Resident Review) with new diagnosis which required further screening, a Level II PASRR to be completed. This was true for 3 of 4 residents (#7, #8, and #13) whose PASRR records were reviewed. This deficient practice had the potential for negative outcomes if the resident was not assessed and cared for or monitored due to inaccurate assessments. Findings include:The Idaho Medicaid Plan Benefit 16.03.26.475.03 dated 7/1/25, documented under change in status, resident reviews for residents with MI or DD must occur and a new determination made after any significant change in their physical or mental condition NFs must notify the Department of any changes within two (2) working days of occurrence when any significant change requires new or increased specialized services.a. Resident #7 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including stroke and chronic obstructive pulmonary disease (a progressive lung disease that makes it hard to breathe). Resident #7's physician order dated 6/14/25, for Lithium Carbonate oral capsule, give 300 mg by mouth two times a day for mood stabilization which is an antipsychotic medication that requires an updated Level I PASRR to be completed and promptly submitted to the state mental health authority within 2 days. On 8/19/25 at 2:10 PM, the facility social services staff #1 stated the facility had not yet filed the updated Level I PASRR document for Resident #7. b. Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including acute hepatitis C (the initial phase of hepatitis C virus (HCV) infection, typically lasting for the first six months after exposure) and alcoholic cirrhosis of the liver without ascites (a condition where the liver is scarred due to excessive alcohol consumption, but without the accumulation of fluid in the abdomen). Resident #8’s Level I and Level II PASRR’s dated 6/20/25, documented his MMI as depressive disorders, anxiety, and agitation. On 6/24/25, Resident #8’s depressive disorder diagnosis was changed to bipolar disorder requiring an updated Level I PASRR be completed and resubmitted and it was not. On 8/19/25 at 2:30 PM, the facility social services staff #1 stated the facility had just filed the updated Level I PASRR document for Resident #8 on 8/18/25 and she was not aware there was a time frame for when the facility had to file the Level I PASRR update. c. Resident #13 was admitted on [DATE], with multiple diagnoses including depressive disorder and schizophrenia. Resident #13’s Level 1 PASRR dated 4/3/17, documented he had a diagnosis of depressive disorder and mental retardation. There was no documentation Resident #13 had a diagnosis of schizophrenia. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #13’s Level II PASRR dated 4/6/17, documented Resident #13 carries a diagnosis of depressive disorder which meets PASRR criteria. He is stable regarding his mental health issues and no further evaluation was needed. There was no documentation Resident #13 had a diagnosis of schizophrenia. On 8/6/25, an updated Level I PASRR was sent to BLTC to include Resident #13’s diagnosis of schizophrenia. On 8/20/25, the DON was asked why the update took 8 years to get the Level I PASRR updated to include his diagnosis of schizophrenia. She stated it was an error the facility did not catch until recently. The DON stated they were still waiting to receive an updated Level II PASRR back from BLTC.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the facility routine standing orders, record review and staff interview, it was determined the facility failed to follow the facility bowel care standing order of delivering specific medications when residents do not have BM within 72 hours for 2 of 8 residents (#7 and #10) who records were reviewed for bowel and bladder care. This failed practice created the potential for residents to experience discomfort when medications were not administered according to the physician's order. Findings include:The facility routine standing orders for nursing home dated 8/28/24, documented for resident constipation the following medications may be used:- Miralax 17gm mix with 8oz fluid QD PRN constipation - Senna 8.6mg 1-2 tabs QD PRN for constipation. - Dulcolax 5mg 1 tab QD PRN - Magnesium Citrate 1 bottle QD PRN constipationa. Resident #7 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including stroke and chronic obstructive pulmonary disease (a progressive lung disease that makes it hard to breathe).Resident #7's medical record documented in the CNA Task Bowel Activity, he had a bowel movement on 7/27/25 documented at 13:55, and not again until 7/31/25 documented at 13:59, 96 hours later.Resident #7's MAR for July 2025, documented bowel management protocol had not been initiated between 7/27/25 and 7/31/25. b. Resident #10 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including diabetes and chronic respiratory failure with hypoxia (a condition where the lungs are unable to adequately oxygenate the blood (hypoxia) over an extended period, often due to underlying respiratory diseases).Resident #10's medical record documented in the CNA Task Bowel Activity, he had a bowel movement on 7/25/25 documented at 21:05, and not again until 7/29/25 documented at 9:50, 84 hours later.Resident #10's MAR for July 2025, documented bowel management protocol had not been initiated between 7/25/25 and 7/29/25.Resident #10's medical record documented in the CNA Task Bowel Activity, he had a bowel movement on 8/9/25 documented at 15:31, and not again until 8/14/25 documented at 10:31, 117 hours later. Resident #10's MAR for August 2025, documented bowel management protocol had not been initiated between 8/9/25 and 8/14/25.On 8/19/25 at 2:00 PM, the DON stated staff should start the bowel management protocol when a resident had no BM for 72 hours or more and had not.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and staff interview, it was determined the facility failed to ensure controlled medications were tracked and kept secure from potential theft and/or diversion. This was true for 2 of 3 medication carts reviewed. This failure created the potential for undetected misuse and/or diversion of controlled medications and had the potential to affect all residents who received controlled medication in the facility. Findings include: On 8/18/25 at 3:49 PM, during East Hall medication cart audit, observed the narcotic accountability record, dated 8/1/25 to 8/18/25, with 3 licensed nurse signatures not documented. On 8/18/25 at 3:52 PM, LPN #2 stated two nurses should have signed the narcotic accountability record when they accepted the medication cart or released the medication cart. On 8/20/25 at 1:50 PM, during North Hall medication cart audit, observed the narcotic accountability record, dated 8/1/25 to 8/20/25, with 1 licensed nurse signature not documented. On 8/20/25 at 1:55 PM, RN #2 stated two nurses should have signed the narcotic accountability record when they accepted the medication cart or released the medication cart.On 8/20/25 at 2:54 PM, the DON stated two nurses should have signed the narcotic accountability record when they accepted the medication cart or released the medication cart.

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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. Based on observation and interviews, it was determined the facility failed to ensure medication carts were locked when unattended. This was observed in 1 of 3 medication carts. This failure created the potential for residents to obtain prescribed medications used for other residents and presented the risk for cross-contamination of medications stored in the cart. Findings include:On 8/18/25 at 9:03 AM, observed an unlocked and unattended medication cart on the TCU hall outside of the dining room. RN #1 came out of the dining room after about 3 minutes and said she was just inside the dining room but stated the medication cart should have been locked. On 8/18/25 at 12:33 PM, observed an unlocked and unattended medication cart on the 200 Hall for over 3 minutes. While standing next to the medication cart, no facility staff were visible to the surveyor at that time. RN #1 was in the chart room on the 200 Hall and stated she did forget to lock the medication cart.On 8/18/25 at 4:08 PM, the DON stated medication carts are to always be locked when unattended and had not been.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and staff interview, the facility failed to ensure adherence to infection control and prevention practices to provide a safe and sanitary environment when staff did not perform hand hygiene prior to providing care from resident-to-resident. This failure had the potential to impact 3 of 3 residents (#5, #17 and #71) observed during resident care, placing them at risk for cross-contamination and infection. Findings include: On 8/20/25 at 8:40 AM, surveyor observed CNA #2 enter Resident #5's room and obtain vital signs; blood pressure, oxygen saturation, and temperature, however CNA #2 did not perform hand hygiene on entering, during care, or exiting Resident #5's room. CNA #2 proceeded down the hall to Resident #71's room.On 8/20/25 at 8:55 AM, surveyor observed CNA #2 enter Resident #71's room and obtain vital signs; blood pressure, oxygen saturation, and temperature, however CNA #2 did not perform hand hygiene on entering, during care, or exiting Resident #71's room. CNA #2 proceeded down the hallway to Resident #17's room.On 8/20/25 at 9:17 AM, surveyor observed CNA #2 enter Resident #17's room and obtain vital signs; blood pressure, oxygen saturation, and temperature, however CNA #2 did not perform hand hygiene on entering, during care, or exiting Resident #17's room.On 8/20/25 at 10:09 AM, CNA #2 stated she had not performed hand hygiene between resident-to-resident care, and she has a bad habit of not doing it.On 8/20/25 at 10:42 AM, the DON stated the CNA should have been performing hand hygiene when providing resident-to-resident care.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to provide a safe and functional environment. This was true for 2 of 2 residents (#2 and #76) whose sharps containers were observed to be overfilled. This failure had the potential for injury and infections. Findings include:On 8/18/25 at 2:43 PM, observed in resident #2's room with LPN #1 present, the sharps container was filled past the full line.On 8/18/25 at 2:45 PM, LPN #1 stated the sharps container should have been changed when it was full.On 8/18/25 at 2:48 PM, observed in resident #76's room with LPN #1 present, the sharps container was filled past the full line.On 8/18/25 at 2:49 PM, LPN #1 stated the sharps container should have been changed when it was full.On 8/19/25 at 9:38 AM, the DON stated the sharps containers should have been changed when full.