

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 08/09/2024
NAME OF PROVIDER OR SUPPLIER Meadow View Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 46 North Midland Boulevard Nampa, ID 83651	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35690</p> <p>Based on record review, interview, and facility policy review, the facility failed protect the resident's right to be free from physical abuse by staff for one of five residents (Resident (R) 13) reviewed for abuse out of a total sample of 21 residents.</p> <p>Findings include:</p> <p>Review of R13's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/12/24, located in the electronic medical record (EMR) under the MDS tab, revealed R13 admitted to the facility on [DATE]. R13 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. Per the MDS, the resident did not exhibit any behaviors during the assessment period.</p> <p>Review of the Resident Allegation of Abuse Investigation, dated 07/26/24, indicated, [R13] . with a primary diagnosis of aftercare following ulna fracture . Resident reported to social services on this date at approximately 9:45 AM to file a grievance against one of the facility's CNAs [Certified Nurse Aides] [CNA4] . [R13] said smoke break was in the process of ending and the aide announced smoke break was over and she needed to get back in the building. [R13] states [sic] she was in the process of taking a drag off her cigarette when [CNA 4] reached over and grabbed her arm and wrist in what she felt was an aggressive manner to put her cigarette out and ended up burning the resident and herself . On 07/26/24 at 10:45 AM, this administrator met with [another resident] . he stated [R13] was taking a smoke off her cigarette and the assistant reached over and grabbed her arm to put her cigarette out . He confirmed he felt it was done in an aggressive manner and was done intentionally. Director of Nursing [DON] will meet with staff member on 07/29/24 (remained on leave until this date) at which time she will be terminated.</p> <p>During an interview on 08/06/24 at 2:41 PM, R13 stated CNA4 grabbed her hand and put the cigarette in the ashtray. R13 stated she was startled she [CNA4] would do something like that. R13 said CNA4 grabbed her wrist, burned her finger and put her cigarette out. R13 stated it was not a bad burn just some redness, but it was enough to scare her. R13 completed a grievance form and then heard from the DON that CNA4 was fired.</p> <p>During an interview on 08/07/24 at 10:30 AM, R30 stated she was in the smoking area when CNA4 grabbed R13's arm. R30 stated she thought both R13 and CNA4 were burned when CNA4 grabbed R13 to put her cigarette out.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/07/24 at 5:00 PM, the Administrator stated she immediately investigated the grievance after hearing about it and terminated CNA4.</p> <p>Review of the facility's policy titled, Abuse: Prevention of and Prohibition Against, dated 12/2023, revealed All identified events are reported to the Administrator immediately . After receiving the allegation, and after the investigation, the Administrator will ensure that all residents are protected from physical and psychosocial harm.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</p> <p>Based on record review, interview, and policy review, the facility failed to investigate an injury of unknown origin and an allegation of sexual abuse for two residents out of five residents (Resident (R) 73 and R63) reviewed for abuse out of a sample of 21. Failure to thoroughly investigate and take appropriate action for allegations had the potential to place other residents at risk of abuse/neglect.</p> <p>Findings include:</p> <p>1. Review of R73's Face Sheet located in the Profile tab of the electronic medical record (EMR), revealed re-admission to the facility on [DATE] with diagnosis of mild cognitive communication deficit.</p> <p>Review of R73's annual Minimum Data Set (MDS), located in the electronic medical record (EMR) under the MDS tab, with an Assessment Reference Date (ARD) of 02/02/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated no cognitive impairment.</p> <p>Review of a Nurse's Note, located in the EMR under the Notes tab, written by Licensed Practical Nurse (LPN) 1, dated 07/03/23 at 12:16 AM, revealed, results from x-ray to residents fifth toe came back, results are acute oblique fractures (break on an angle) are seen in the distal fourth and fifth metatarsals.</p> <p>Review of facility provided Incident report, dated 07/03/24 at 8:42 AM, revealed R73 was seen by the in-house podiatrist with an order to obtain an x-ray of the right 5th toe to rule out bone lesions. X-ray performed and results were an acute oblique fracture are seen in the distal fourth and fifth metatarsals.</p> <p>During an interview on 08/08/24 at 11:21 AM, LPN1 stated staff should notify the Administrator or main supervisor within 2 hours of any abuse concern or an injury of unknown origin. She said she was the nurse on shift when the results for R73's x-ray came back. But she was not sure if she reported the fractures to anyone, but she should have reported it to a supervisor and if she did, she should have documented that.</p> <p>During an interview on 08/07/24 at 6:22 PM the Director of Nursing (DON) stated they investigated R73's broken toes and provided a paper with five questions dated 07/09/24 but did not have any additional documentation. The questions were conducted six days after x-ray results were received by the facility. The DON did not know how R73's toes were broken. No additional documentation related to an investigation was provided.</p> <p>36917</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of the "Bureau of Facility Standards Long Term Care Reporting system, dated 08/08/24 and completed by the Administrator, revealed a report of sexual abuse for R63 as reported by Licensed Practical Nurse (LPN) 7. The document was provided by the administrator as the incident report that was submitted to the State Survey Agency. The form did not indicate the date or time the report was online submitted. The "incident type" as documented on the form indicated "resident to resident incident (verbal, physical, mental, or sexual) was not marked to specify sexual abuse. The incident description documented "during routine rounds licensed nurse observed resident [R49] in the room of [R63] being affectionate, [R49] cooperated with being immediately redirected out of room to his room next door to [R63], family members of both residents were notified and aware of the situation. The "immediate protective action plan" documented on the form stated R63 and R49 were immediately separated, R49 was placed on 15-minute monitoring checks for intrusive wandering and referred to Nurse Practitioner on 07/15/24 to assess for any medical status changes. The document indicated R63 frequently invited passersby into her room and was being monitored for any psychosocial changes related to the incident.</p> <p>Review of R63's "Face Sheet," located in the "Profile" tab of the EMR, revealed an admitted [DATE] with diagnoses to include but not limited to unspecified dementia with other behavioral disturbance, anxiety disorder, cognitive communication deficit, need for assistance with personal care, unspecified psychosis, and depression.</p> <p>Review of R63's "MDS, located in the MDS tab of the EMR, with an ARD of 06/06/24, revealed a BIMS score of 4 out of 15 which indicated R63 was severely cognitively impaired.</p> <p>Review of R63's care plan, located in the Care Plan tab of the EMR and revised 07/15/24, revealed she was at risk for impaired cognitive function, Activities of Daily Living (ADL) self-care performance deficit, altered mood/behaviors, evidenced by yelling out to people passing her door to come into her room, and physically aggressive, with a history of wandering.</p> <p>The "Nursing Progress Notes," located in the Progress Notes tab in the EMR, documented R63's family member was not concerned with leaving R49 next door to his mother. Also documented in the progress note was his comment that R63 frequently tried to kiss him inappropriately and was easily redirected.</p> <p>During an interview on 08/08/24 02:21 PM with R63 in her room with Caregiver (CGR) 1 present, R63 stated she did not remember any "boys" or men coming into her room or kissing her. R63 responded that no boys entered her room. R63 appeared happy and smiling with no fear of any "boys" coming into her room.</p> <p>Review of R49's "Face Sheet," located in the "Profile" tab of the EMR, revealed an admitted [DATE] with diagnosis to include but not limited to mild dementia without behavioral disturbance. mild cognitive deficit, ambulatory and independent for ADL.</p> <p>Review of R49's "MDS, located in the MDS tab of the EMR, with an ARD of 07/04/24, revealed a BIMS score of 15 out of 15 which indicated R63 was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R49's care plan, located in the Care Plan tab of the EMR, dated and revised 07/04/24, revealed R49 had a language barrier and was Spanish speaking only. R49's care plan revealed he had a history of engaging in unwelcome sexual behaviors and non-reciprocated sexual advances toward others as evidenced by grabbing others, kissing others, and intrusive wandering, initially dated 07/01/20 and revised 07/15/24. Interventions included redirecting resident and assisting him to develop more appropriate methods of coping and interacting with others, and to protect other residents by closely monitoring his possible behaviors, counseling with him as needed to stay out of other resident rooms.</p> <p>Review of Practitioner Progress Note, located in the EMR Progress Notes tab and dated 07/17/24, documented the following, "During a recent visit on 07/16/2024, [R49] was found in [R63's] room being affectionate, likely due to cognitive deficits from a previous subdural hemorrhage. He was placed on 15-minute checks and alert charting.</p> <p>During an interview on 08/07/24 at 5:36 PM, the Director of Nursing (DON) stated he had written a summary of the incident, but did not have documented evidence of date, time, or name of residents or staff that he had interviewed after the alleged abuse incident.</p> <p>On 08/08/24 at 8:39 AM, the DON provided a sheet of paper that contained the three questions below, along with the signatures of three residents, R17, R23, and R50.</p> <p>Has any person come into your room that has been uninvited?</p> <p>Has any male, resident or staff come into your room that has been uninvited.</p> <p>Has anyone resident or staff been wandering into your room that has been uninvited?</p> <p>No documentation of the interview conversation or the answers provided by the residents in response to the questions was provided.</p> <p>During an interview on 08/08/24 at 10:22 AM, the Administrator stated she was not aware of the care plan entry for R63 that documented his previous history of inappropriate behaviors and sexual advances and wandering into other resident's rooms. When asked about measures implemented to prevent further possible abuse of other residents, the Administrator stated she had discussed with other staff and family members about moving R49 and his spouse to another room/hall, but there were no other rooms available in the facility for a couple. The Administrator stated that additional craft and activity items were ordered for R63 on 07/15/24 to give R63 more things to do. The Administrator stated a "owl" door motion detector alarm was ordered and placed on the door of R63's room that would alert (by sounding loudly at her door) staff of anyone entering R63's room.</p> <p>Documentation of a "15 Minute Check List" of R63 was provided by DON. The documents indicated inconsistent random checks performed daily from 07/14/24 through 08/07/24. The DON stated R63 was only monitored during the same shift the initial allegation occurred on.</p> <p>During a phone interview on 08/08/24 at 4:34 PM, LPN7 recalled R49 standing in R63's room beside the recliner of R63 with his hands touching her face and her arms around his neck with their lips touching. LPN7 stated she calmly directed R49 out of R63's room and back to his room next door and then reported the incident to the administrator.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled "Abuse Reporting and Investigation," revised February 2024, revealed "all reports of resident abuse, neglect, and injuries of unknown source shall be thoroughly and promptly investigated by the facility."</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</p> <p>Based on record review, interview, and policy review, the facility failed to implement a care plan for a resident with a known history of wandering and exit seeking behaviors for a resident who gained access to the facility parking lot without staff supervision or knowledge for one of three residents (Resident (R) 95) reviewed for elopement. This has the potential to affect all residents who were at risk of wandering and elopement.</p> <p>Findings include:</p> <p>Review of R95's Face Sheet located in the Profile tab of the electronic medical record (EMR), revealed re-admission to the facility on [DATE] and with diagnoses including attention and concentration deficit, aphasia, and memory deficit.</p> <p>Review of R95's annual Minimum Data Set (MDS), located under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 05/24/24, revealed the Brief Interview for Mental Status (BIMS) could not be completed due to resident rarely being understood.</p> <p>Review of R95's care plan, located under the "Care Plan" tab of the EMR and dated 03/18/24, revealed the resident was an elopement risk/wanderer due to a history of attempts to leave the facility unattended.</p> <p>Review of a Nurse's Note, located in the EMR under the Notes tab, written by Former Social Worker (FSW) on 08/15/23 at 1:51 PM, revealed, it was brought to the attention of the social worker that R95 has been gathering his stuff and trying to get to the front door of the facility to leave. Staff spoke with R95 who continued to wheel himself down the hall. After the Director of Nursing (DON) spoke with R95 he agreed to stay.</p> <p>Review of a Nurse's Note, located in the EMR under the Notes tab, written by Licensed Practical Nurse (LPN) 8 on 12/13/23 at 6:04 PM, revealed R95 continued on alert charting for increase in wandering.</p> <p>Review of a Nurse's Note, located in the EMR, under the Notes tab, written by Licensed Practical Nurse (LPN) 2 on 03/16/24 at 5:39 PM indicated, R95 was outside in front parking lot, staff assisted R95 back inside the facility, unable to determine why R95 went outside into parking lot.</p> <p>During an interview on 08/07/24 at 6:22 PM, the Director of Nursing said the interdisciplinary team (IDT) was aware R95 had known wandering behaviors and a documented desire to leave the facility, and he was not sure why nothing was put into place prior to 03/16/24 but stated they should have definitely put interventions in place.</p> <p>During an interview on 08/08/24 at 3:31 PM, the Former Social Worker (FSW) stated after staff became aware R95 verbalized a desire to leave the facility and exhibited an increase in wandering which made him an elopement risk it should have been care planned.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy title Comprehensive Person-Centered Care Planning, reviewed 12/2023, revealed it is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychological needs that are identified in the comprehensive assessment.</p> <p>A review of the facility's course transcript titled Wandering and Elopement, dated 2023 revealed once a resident has been identified as being high risk for elopement, develop an interdisciplinary plan of care that includes prevention strategies.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</p> <p>Based on observations, record review, and interview, the facility failed to provide services based on acceptable standards of practice by specifically failing to accurately check a finger stick glucose level and failing to administer nebulized medication correctly for two of two residents (Resident (R) 48 and R103) reviewed for professional standards of 21 sample residents.</p> <p>Findings include:</p> <p>1. Review of R48's Face Sheet, located under the Resident tab of the electronic medical record (EMR), documented R48 was admitted to the facility on [DATE] with a diagnosis of type two diabetes mellitus with chronic kidney disease.</p> <p>Review of R48's annual Minimum Data Sheet (MDS) with an Assessment Reference Date (ARD) of 06/28/24, located under the MDS tab of the EMR, documented R48 had a Brief Interview for Mental Status (BIMS) of 13 out of 15 indicating, R48 was cognitively intact.</p> <p>Review of R48's care plan, dated 08/06/24 and located under the Care Plan tab of the EMR, documented R48 had diabetes mellitus and would remain free of signs and symptoms of hypoglycemia through the next review date.</p> <p>Review of R48's active orders for August 2024, located under the Orders tab of the EMR, indicated to check blood sugar before bedtime to make sure the resident was not hypoglycemic.</p> <p>During an observation on 08/08/24 at 11:07 AM, Licensed Practical Nurse (LPN) 3 checked R48's blood sugar. LPN3 cleaned R48's finger with an alcohol wipe prior to sticking R48's finger with the lancet. LPN3 then used the dirty alcohol pad to wipe away the first drop of blood prior to obtaining the blood sample.</p> <p>During an interview on 08/08/24 at 11:20 AM, LPN3 stated she should have used a clean alcohol pad or a dry cotton ball/gauze to wipe away the first drop of blood. LPN3 stated she accidentally picked up the dirty alcohol swab.</p> <p>During an interview on 08/08/24 at 3:20 PM, the Director of Nursing (DON) stated you should introduce yourself, explain what you are going to do, and gather your supplies. The DON stated you then cleanse the finger with alcohol, let it air dry, stick the finger with the lancet, discard the first drop of blood with gauze and not the alcohol pad, and then use the next drop for the test sample.</p> <p>During an interview on 08/08/24 at 5:36 PM, the DON stated he did not have a policy regarding how to properly check a blood sugar. He stated they just follow physician orders.</p> <p>2. Review of R103's Face Sheet, located under the Resident tab of the EMR, documented R103 was admitted to the facility on [DATE] with diagnoses which included obstructive sleep apnea and morbid obesity.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R103's admission MDS with an ARD of 07/01/24, located under the MDS tab of the EMR, documented R103 had a BIMS of 15 out of 15, indicating she was cognitively intact.</p> <p>Review of R103's care plan, dated 07/01/24 and located under the Care Plan tab of the EMR, indicated R103 had chronic obstructive pulmonary disease (COPD, a lung disease causing restricted air flow), shortness of breath (SOB) and wheezing. The care plan indicated R103 would be free of signs or symptoms of infection through review date and aerosol bronchodilators would be given as ordered.</p> <p>Review of R103's current physician orders, located under the EMR Orders tab, dated August 2024, documented the following order, started 07/02/24, Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML inhale one vile three times a day for COPD.</p> <p>During an observation on 08/08/24 at 1:06 PM, LPN6 administered a nebulizer breathing treatment to R103. Ipratropium bromide (a medication used to treat COPD) one ampule was administered. A clear liquid was observed in the medication chamber when LPN6 and the surveyor entered the room. LPN6 added the ampule of ipratropium to the medication chamber and began the treatment. R103 was observed coughing. R103 stated she took the breathing treatments for her COPD diagnosis.</p> <p>During an interview on 08/08/24 at 1:13 PM, LPN6 stated he did not notice the liquid in the medication chamber prior to adding the current dose of medication. LPN6 stated the equipment should be rinsed, dried and stored in a plastic bag between each use. LPN6 stated he should have checked the chamber to ensure it was clean and ready for use.</p> <p>During an interview on 08/08/24 at 3:20 PM, the DON stated the nursing staff should check the respiratory equipment prior to use and ensure they are clean, free of debris, residue, or liquids. The DON stated staff should rinse the equipment after it is used, let it dry, and then place it in a plastic bag.</p> <p>Review of the undated document provided by the Administrator and obtained at lung.org titled ABCs of Using a Nebulizer indicated the following: 1. After each treatment, disassemble and wash the nebulizer part in warm soapy water or in the dishwasher 2. Rinse and let the pieces air dry and store in [a] clean dry place.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</p> <p>Based on observation, record review, interview, and policy review, the facility failed to ensure a residents safety during a mechanical lift transfer resulting in the resident falling during a mechanical lift transfer and sustaining a spinal fracture and to prevent a cognitively impaired resident with wandering/exit seeking behaviors from gaining access to the parking lot without supervision for two of seven residents (Resident (R) 309 and R95) reviewed for accidents in the sample of 21.</p> <p>Findings include:</p> <p>1. Review of R309's Face Sheet, located in the Profile tab of the electronic medical record (EMR), revealed admission to the facility on [DATE] and readmitted on [DATE] with diagnoses including fracture of T7-T8 thoracic vertebra.</p> <p>Review of R309's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/28/24 revealed a Brief Interview for Mental Status (BIMS) could not be completed due to resident rarely being understood.</p> <p>Review of R309's care plan, located under the Care Plan tab of the EMR and dated 05/24/17, revealed, The resident was at risk for Activities of Daily Living (ADL) self-care performance related to profound intellectual disabilities. Interventions in place for transfer were that patient was dependent on staff for transfers and required two staff for Hoyer [mechanical lift] transfers.</p> <p>Review of a Nurse's Note, located in the EMR under the "Notes" tab, written by Licensed Practical Nurse (LPN) 4 on 06/29/24 at 5:35 PM revealed, called to resident room to assist with Hoyer transfer, resident in sling and ready for transfer when I arrived, I had the Hoyer control, lifted resident off the bed enough to move. As resident was being turned toward her chair the loop at her right hip came undone and resident slid feet first onto the floor.</p> <p>Review of Incident report, provided by the facility and dated 06/29/24 at 5:42 PM, revealed resident fell out of Hoyer during transfer. Left hoop came undone and resident slid feet first onto the floor. Resident still low to the floor at the time of the fall, her head landed on this nurse's foot, right shoulder onto Hoyer wheel. Resident is nonverbal.</p> <p>Review of Hospital Progress Notes, located under the Miscellaneous tab of the EMR and dated 06/20/24, revealed R309 was brought into the emergency room after a fall out of a mechanical lift and was assessed and found to have a T8 compression fracture.</p> <p>(continued on next page)</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 08/09/2024
NAME OF PROVIDER OR SUPPLIER Meadow View Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 46 North Midland Boulevard Nampa, ID 83651	
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)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/07/24 at 3:53 PM, LPN4 said Certified Nurse Aide (CNA) 4 asked her to assist with a mechanical lift transfer and she told CNA4 to give her a second. LPN4 recalled when she entered R309's room the resident was in bed and the sling was under her and hooked up. LPN4 stated she glanced at the loops, but she did not physically check them. CNA4 had the resident, and LPN4 took the mechanical lift control. As she lowered R309, the loop on the left hip came undone and R309 slid out, LPN4 grabbed her head but R309 hit the back of her leg on the lift. LPN4 assessed her, checked her back, the resident seemed alright and was responding at baseline, no range of motion at baseline, put her back into sling and then into her wheelchair. After a few minutes R309's face went pale and her breathing was rapid, called 911, and she was sent to the emergency room .</p> <p>An attempted call was placed on 08/08/24 at 11:24 AM to CNA4 but it was unsuccessful.</p> <p>During an interview on 08/08/24 at 1:42 PM, CNA1 said he was very familiar with R309 and was assigned to her regularly. CNA1 said staff should have checked the loops before R309 was lifted for safety. CNA1 said it was something that should and could be easily checked for to ensure its secure prior to lifting the resident and the fall that occurred was easily preventable.</p> <p>During an interview on 08/07/24 at 6:22 PM, the Director of Nursing (DON) stated he expected that all transfers be done with two people, and they should be focused on what they are doing. The DON stated the facility identified that the loops during R309's transfer were not secured causing them to come undone and resulting in her falling out of the mechanical lift.</p> <p>A review of the facility's policy title Safe Resident Handling/Transfers reviewed on 01/01/2023, revealed, it is the policy of the facility that the residents will be transferred/handled safely.</p> <p>2. Review of R95's Admission Record located in the Profile tab of the EMR, revealed re-admission to the facility on [DATE] and with diagnoses including attention and concentration deficit, aphasia, and memory deficit.</p> <p>Review of R95's annual MDS, located under the MDS tab of the EMR, with an ARD of 02/29/24, revealed the BIMS could not be completed due to resident rarely being understood. Further review revealed his cognitive skills were moderately impaired due to poor decision making and he required cues/supervision.</p> <p>Review of R95's care plan, located under the "Care Plan" tab of the EMR and dated 03/18/24, revealed the resident was an elopement risk/wanderer due to a history of attempts to leave the facility unattended.</p> <p>Review of a Nurse's Note, located in the EMR under the Notes tab by Former Social Worker (FSW) on 08/15/23 at 1:51 PM, revealed, it was brought to the attention of the social worker that R95 has been gathering his stuff and trying to get to the front door of the facility to leave. Staff spoke with R95 who continued to wheel himself down the hall. After the DON spoke with R95 he agreed to stay.</p> <p>Review of a Nurse's Note, located in the EMR under the Notes tab, written by Licensed Practical Nurse (LPN) 8 on 12/13/23 at 6:04 PM, revealed R95 continued on alert charting for increase in wandering.</p> <p>(continued on next page)</p>		

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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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a Nurse's Note, located in the EMR under the Notes tab, written by Licensed Practical Nurse (LPN) 2 on 03/16/24 at 5:39 PM, indicated, R95 was outside in front parking lot, staff assisted R95 back inside the facility, unable to determine why R95 went outside into parking lot located about 20 feet from a main road.</p> <p>A review on weather.com revealed the weather forecast in Nampa, ID on 03/16/24 was 48 degrees that day and 37 degrees that night.</p> <p>During an interview on 08/07/24 at 3:55 PM, Licensed Practical Nurse (LPN) 2 said she was not sure how often the facility has training related to elopement or when the last one she attended was. LPN2 said she was not sure what the elopement protocol was, but she believed staff would go look for them, call 911 if they were unable to find them and the Administrator and Director of Nursing (DON) should be made aware. LPN2 said on 03/16/24 a CNA alerted her that R95 was in the parking lot, but she could not remember who the CNA was. LPN2 did not know how long R95 had been in the parking lot, but she said staff were not present with him and did not know he was out there. LPN2 was just told he was out there, and she did not ask the CNA any questions. LPN2 stated when she went to walk out to the parking lot, she observed another staff (unsure who) assisting R95 back inside. LPN2 thought she reported it to the on-call supervisor but unsure who that was. LPN2 said R95 was not a wanderer or elopement risk prior to that, and he did not have any interventions related to elopement or wandering and she was unaware of any other incidents with that resident or other residents. LPN2 said R95 was in the parking lot in his wheelchair, but she could not remember what he was wearing but she thought it was appropriate for the weather at the time.</p> <p>During an interview on 08/07/24 at 4:27 PM, the Assistant Director of Nurse (ADON) said that on 03/16/24 LPN2 called and told her R95 wheeled out the front doors and he was seen outside the front doors. The ADON stated after that staff put a wander guard on him to ensure he did not go out the front door again. The ADON could not recall if someone saw him go out the front door or if staff saw him outside the front door, and she did not know for sure how R95 actually got out of the facility or how long he was outside before staff observed him.</p> <p>During an interview on 08/07/24 at 6:22 PM, the DON said they did not have any documentation related to the elopement. The DON stated they did not report or investigate it, and they were waiting on guidance from the state because they did not consider the incident an elopement. The DON said the interdisciplinary team was aware R95 had known wandering behaviors and a documented desire to leave the facility, and he was not sure why nothing was put into place prior to 03/16/24 but stated they should have definitely put interventions in place.</p> <p>A policy was not provided for wandering/elopement.</p>		