

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135139	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER Sunterra Springs Riverview		STREET ADDRESS, CITY, STATE, ZIP CODE 3550 West Americana Terrace Boise, ID 83706	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>50981</p> <p>Based on observation, policy review, and resident and staff interview, it was determined the facility failed to ensure residents' bedroom temperatures were maintained at a comfortable level. This was true for 3 of 30 residents (#10, #127, and #144) whose bedrooms were observed. This deficient practice created the potential for harm if residents became too cold or hot and it compromised their health status. Findings include:</p> <p>The Centers for Medicare and Medicaid Services (CMS) State Operations Manual (SOM) Appendix PP, rev. 225; issued: 8/8/24, S483.10(i) defines comfortable and safe temperature levels as the ambient temperature should be in a relatively narrow range that minimizes residents' susceptibility to loss of body heat and risk of hypothermia, or hyperthermia, or and is comfortable for the residents.</p> <p>The facility's Resident Environment Quality policy, dated 7/2021 and revised 6/2023, documented, resident rooms and activity areas should be of a comfortable temperature for the resident. Resident behavior should be observed (wearing sweaters, wrapping in blankets, etc.) to determine the appropriate temperature levels.</p> <p>1. On 1/22/25 at 2:17 PM, Resident #10 stated his room is always too cold. He was observed sitting in a chair in his bedroom with a thick blanket over his lap. Resident #10 stated he told staff about it, and they adjusted the thermostat, but the room was still cold. The wall thermostat control unit was set at 78 degrees Fahrenheit (F), and the thermostat documented the room temperature was 73 degrees F. During the observation it was noted that his room felt drafty and cold.</p> <p>On 1/23/25 at 8:43 AM, the Director of Nursing (DON) confirmed the wall thermostat in Resident #10's room was set at 78 degrees F, the thermostat showed the room was 73 degrees F. The DON stated she did not feel the room was too cold although was noted to be wearing a wool winter coat during the observation. The DON stated the Maintenance Director would check the temperature in the bedroom using an ambient temperature gauge.</p> <p>On 1/23/25 at 12:57 PM, the Maintenance Director stated he was able to check the thermostats for the resident bedrooms from his computer. He added it should not have felt cold in Resident #10's bedroom because his computer was showing the thermostat was set to 75 degrees F and showing the room to be 75 degrees F, but he had not gone to the room to take the ambient air temperature reading.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/23/25 at 1:00 PM, Resident #10 was in his bedroom sitting in his chair with a heavy blanket on when the Maintenance Director was observed measuring the ambient temperature of Resident #10's bedroom to be 71 degrees F. The Maintenance Director added the ambient temperature should have measured closer to the thermostat reading and thought the thermostat may need to be repaired.</p> <p>2. On 1/22/25 at 3:31 PM, Resident #127 stated her room is always too cold, especially the bathroom. She was observed sitting in her bedroom in a chair with a thick blanket over her and pulled up to her chin. She stated the cold makes my joints hurt and going into the bathroom is like going to the north pole and the toilet seat feels like sitting on an iceberg. The bathroom door was observed to be open, and a cold draft was felt blowing into the bedroom. Resident #127 stated she told staff about it and the staff placed towels on the toilet seat for warmth, and the toilet seat was observed to have towels draped over it.</p> <p>On 1/23/25 at 8:40 AM, Resident #127 was observed telling the DON she asked staff to turn the heat up, and it improved but the bedroom and bathroom were still too cold and was causing her pain. The thermostat was observed to be set at 76 degrees F and read the temperature in the bedroom was 70 degrees F, the bathroom was noted to be substantially colder than the bedroom.</p> <p>On 1/23/25 at 12:57 PM, the Maintenance Director stated if Resident #127 told staff she was cold, those staff did not report that information to him and he was unaware of her concerns. He added his computer documented the room was within 71-81 degrees F as regulation stated.</p> <p>On 1/23/25 at 1:05 PM, Resident #127 was observed sitting in the chair in her bedroom with the same heavy blanket covering her from the chest down, she stated the room was a little bit warmer but it her joints were still bothering her because it was too cold. The Maintenance Director confirmed the thermostat was set at 75 degrees F and read the temperature to be 76 degrees F, he then tested the temperature next to the ceiling vent with the ambient temperature gauge and stated it read 77 degrees F. The Maintenance Director was then observed measuring the ambient air temperature in the bathroom, which read to be 68 degrees F.</p> <p>3. On 1/22/25 at 3:51 PM, Resident #144 stated her room was too cold in the mornings and too hot in the evenings, and she had to keep her bedroom door open to let the heat out. Her room was noticeably very warm, and the door was open during the observation.</p> <p>On 1/23/25 at 8:38 AM, Resident #144 was observed sitting in the chair in her bedroom and telling the DON her room was too cold and requested a lap blanket. The thermostat was observed set to 69 degrees F and the thermostat read the room was 68 degrees F. Resident #144's room was noted to feel cool and cold air was felt blowing from the ceiling vent.</p> <p>On 1/23/25 at 1:08 PM, Resident #144 was observed telling the Maintenance Director she would like to move to another room because it was too cold in the mornings and too hot in the evenings, and she was uncomfortable. He responded by saying there were no other rooms available and the temperature fluctuation was likely caused by the large windows in her room. The thermostat was observed to be set to 75 degrees F and read the room was 77 degrees F. When he tested the ambient temperature of the bedroom it was 71 degrees F.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/23/25 at 3:00 PM, the Administrator stated none of the resident rooms were reading on the Maintenance Directors computer to be out of the 71-81 degrees F range specified in the regulation, but the facility policy documented the residents bedrooms and common areas needed to be a kept at a comfortable temperature for the residents.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50981</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure pharmacy recommendations were followed or addressed by the attending physician. This was true for 2 of 5 residents (Resident #4 and #10) reviewed for pharmacy recommendations and had the potential for harm if residents' medications were administered without a clinical rationale. Findings include:</p> <p>The facility's policy for Pharmacy Medication Regimen Review (MRR), undated, stated the pharmacist will send monthly medication reviews to Director of Nursing (DON)/Designee who then prints the pharmacist recommendations and give to the medical provider to review and sign.</p> <p>1. Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including displaced fracture of first, second, third, and fourth metatarsal bones of the right foot, depression, and anxiety.</p> <p>A physician's order, dated 12/23/24, with no end date, documented Resident #4 was prescribed alprazolam 0.25 mg once daily as needed for depression.</p> <p>A pharmacy consultation report, unsigned by the physician, dated 1/8/25, documented Resident #4's alprazolam order currently had no stop date and per regulations all PRN psychotropic medications must be re-evaluated by provider after 14 days to see if continuation is justified.</p> <p>2. Resident #10 was admitted to the facility on [DATE], with diagnoses which included orthopedic aftercare for surgical amputation and osteomyelitis (infection of the bone).</p> <p>A physician's order dated 12/31/24, documented Resident #10 was prescribed vancomycin 1,000 mg, intravenous every 24 hours for his osteomyelitis.</p> <p>A pharmacy consultation report, unsigned by the physician, dated 1/8/25, documented Resident #10's vancomycin order was missing a duration of therapy and recommended a duration of at least 6 weeks when used to treat osteomyelitis.</p> <p>On 1/24/25 at 1:00 PM, the DON stated they had received the pharmacy recommendations for the month of December 2024 on 1/8/25 and the physician would review December 2024's MRR's at the January Quality Assurance and Performance Improvement (QAPI) meeting, scheduled to be held the third week of the month, but was rescheduled due to survey entrance. The DON stated she could not provide evidence the physician had addressed the pharmacist' recommendation for Resident #4's alprazolam or Resident #10's vancomycin.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48401</p> <p>Based on medical record review and staff interview, it was determined the facility failed to ensure accuracy of 1 of 12 resident records reviewed. This was true for Resident #146 and placed him at risk for harm when he was administered a medication that was listed on his allergy list. Findings include:</p> <p>Resident #146 was admitted to the facility on [DATE] for care following a lumbar fracture.</p> <p>On 1/24/25 Resident #146's medical record documented he had an allergy to opioid analgesics. Resident #146's physician orders and medication administration record (MAR) documented he had been prescribed and was receiving oxycodone (an opioid analgesic) since 12/15/24.</p> <p>On 1/24/25 at 11:10 AM, the DON confirmed Resident #146's allergy list documented he had an opioid analgesic allergy and he had been prescribed and had received opioid analgesics without complication.</p> <p>On 1/24/25 at 11:25 AM, the DON stated the documents from the transferring hospital did not include an allergy to opioid analgesics and it appears it was transcribed to his allergy list in error. The DON confirmed this error in Resident #146's medical record went unnoticed when his physician orders were verified and with each opioid medication administration.</p>		