



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

January 27, 2015

Bradley M. Hruza, Administrator
Valley Vista Care Center of St Maries
820 Elm Street
St Maries, ID 83861-2119

Provider #: 135075

Dear Mr. Hruza:

On **January 12, 2015**, we conducted an on-site follow-up revisit to verify that your facility had achieved and maintained compliance. We had presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **November 17, 2014**. However, based on our on-site follow-up revisit conducted **January 12, 2015**, we found that your facility is not in substantial compliance with the following participation requirements:

F280 -- S/S: E -- 42 CFR §483.20(d)(3), 483.10(k)(2) -- Right to Participate Planning Care - Revise CP

F329 -- S/S: D -- 42 CFR §483.25(l) -- Drug Regimen is Free From Unnecessary Drugs

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form 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. **Please provide ONLY ONE completion date for each federal and state tag 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 both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your copy of the Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed. Your Plan of Correction (PoC) for the deficiencies must be submitted by

February 9, 2015.

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.
- 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 both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

As noted in the letter of November 7, 2014, following the Recertification and State Licensure survey of October 24, 2014, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **April 24, 2015**, if substantial compliance is not achieved by that time. On **December 23, 2014**, CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after **January 7, 2015**
- A 'per instance' civil money penalty of \$3500.00.

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, it will provide you with a separate formal notification of that determination.

Bradley M. Hruza, Administrator

January 27, 2015

Page 3 of 3

If you believe the deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care, 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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:

<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)

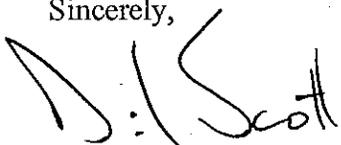
2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **February 9, 2015**. If your request for informal dispute resolution is received after **February 9, 2015**, 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 on-site follow-up revisit. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626, Option #2.

Sincerely,



DAVID SCOTT, R.N., Supervisor
Long Term Care

DJS/dmj
Enclosures

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/12/2015
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NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES	STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861
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(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
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{F 000}	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the followup to the annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Arnold Rosling RN, BSN, QIDP Lauren Hoard RN, BSN</p> <p>The survey team entered the facility on January 12, 2015 and exited on January 12, 2015.</p> <p>Survey Definitions: ADL = Activities of Daily Living BID = Two Times a Day BIMS = Brief Interview for Mental Status CNA = Certified Nurse Aide CPAP = Continuous Positive Airway Pressure DON = Director of Nursing GM = Gram HS = Before Sleep, At Bedtime IM = Intramuscular LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment MG = Milligram PCP = Primary Care Provider PO = By Mouth PRN = As Needed TAR = Treatment Administration Record TID = Three Times a Day</p>	{F 000}	<p>This Plan of Correction does not constitute an admission or agreement by the provider of the truth if the facts alleged or the conclusion set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because the provisions of the federal and state law require it. This provider maintains that the alleged deficiencies do not individually, or collectively, jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the provider asserts that it is in substantial compliance with regulations governing the operation and licensure of long term care facilities, and this Plan of Correction, in its entirety, constitutes this providers allegation of compliance.</p> <p>Completion dates are provided for the procedural procession purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider</p>	
{F 280} SS=E	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or</p>	{F 280}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *NHA* (X6) DATE *2/3/15*

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.

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

PRINTED: 01/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/12/2015
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES		STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
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{F 280}	<p>Continued From page 1 changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs; and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT Is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a care plan was revised after an antipsychotic medication was discontinued. This was true for 1 of 7 (#4) sampled residents. The deficient practice had the potential to cause more than minimal harm when Resident #4's care plan was not updated with accurate information affecting their care in the facility. Findings include:</p> <p>Resident #4 was admittted to the facility on 3/14/11 with multiple diagnoses which included dementia with behavioral disturbance and psychosis.</p> <p>Physician's Telephone Orders for Resident #4, dated 11/3/14, documented, "GDR [Gradual Dose Reduction] of Seroquel to 25 mg PO Q HS [Milligrams By Mouth Every Bedtime] x 7 days</p>	{F 280}	<p>Is under the opinion it was in compliance with requirements of participation or that correctlve action was necessary.</p> <ol style="list-style-type: none"> 1. Resident #4's comprehensive care plan for Seroquel was discontinued immediately on 01/12/15 to reflect her nonuse of the medication. 2. All residents with psychotropic medication care plans have the potential to be affected. All psychotropic medication care plans were audited 01/13/15. Through weekly IDT chart review, quarterly MDS review and prn change of status review and monthly care plan audits residents will be identified for care plan updates. 3. The DNS or designee will check new orders from the physician starting 01/13/15 and compare them to the care plans to assure that psychotropic medication care plans are kept current. Monthly care plan audits and prn change of status reviews were initiated 01/13/15 	01/13/15

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{F 280}	Continued From page 2 then d/c [discontinue]. The December 2014 and January 2015 Medication Administration Record (MAR) for Resident #4 did not contain documentation the resident received Seroquel per Physician Orders. Resident #4's medical record contained a Care Plan for Seroquel Use with an origin date of 3/20/13. Interventions included monitoring for side effects of the medication, Interdisciplinary Team review for appropriateness for continuation of medication and monitoring for effectiveness. On 1/12/15 at 1:55 PM, the Administrator, DON and Unit Manager #1 were interviewed. They said the nurses or management team were responsible for updating care plans, and there was daily monitoring of new orders and weekly care plan monitoring. When asked if Resident #4 was receiving Seroquel, the Unit Manager stated, "No," and the care plan should be changed. On 1/12/15 at 3:30 PM, the Administrator said the issue on Resident #4's care plan should have been caught. On 1/12/15 at 4:45 PM, the Administrator and DON were informed of the care plan issue. No further information was provided.	{F 280}	and will continue for three months. 4. The DNS or designee will follow this issue in QA review by a monthly care plan audit and prn change of status reviews and report to the QA committee beginning 01/13/15. After three months the QA committee will determine the necessity of ongoing audits.	
{F 329} SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	{F 329}	1. A clarification for clear indication of use for PRN Ativan was received for resident #18 01/13/15 from PCP. Staff in-servicing was done on 01/13/15 for new facility protocol for PRN	01/13/15

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(F 329)	<p>Continued From page 3</p> <p>Indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a resident receiving duplicate therapy with antidepressant medications had clinical justification for use, clear indications of when to use, and monitoring. In addition, a resident receiving an anti-anxiety medication did not have clear indications for its use. This was true for 2 of 7 (#s 18 & 19) sampled residents. This practice placed residents at risk for unanticipated declines or newly emerging or worsening symptoms. Findings included:</p> <p>1. Resident #19 was readmitted to the facility on 8/4/14 with multiple diagnoses which included depression and insomnia.</p>	(F 329)	<p>psychotropic medications and proper monitoring, justification and documentation for PRN usage for resident #19.</p> <p>2. All residents that use PRN psychotropic medications have the potential to be affected. Through admit assessment audits, quarterly MDS review and prn change of status review and regular monitoring from the behavior care RN for adequate indication for use and appropriate dose, residents with the potential for unnecessary medications will be identified.</p> <p>3. Physician orders with a range in dosage for PRN psychotropic medications will be clarified with physician for appropriate dose to be given during breakthrough anxiety. Facilities escalating behavior protocols for administration of PRN psychotropic medications will be modified to indicate what dose is to be given at what stage of the protocol per physician. Clinical</p>	

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{F 329}	<p>Continued From page 4</p> <p>Resident #19's most recent quarterly MDS assessment, dated 11/7/14, documented the resident received an antidepressant medication 7 out of 7 days.</p> <p>The Mood/Behavioral Alteration Care Plan for Resident #19, with an origin date of 8/4/14, documented the goal, "Depression symptoms will not worsen. Medications will be used at the lowest dose possible." Interventions included medications as ordered by physician and monitoring for signs and symptoms of depression.</p> <p>The November and December 2014, and January 2015 Physician Order Flow Sheets for Resident #19 included the orders for Lexapro 20 mg (milligrams) by mouth daily for depression with anxiety and Trazodone 50 mg by mouth at bedtime as needed (PRN) for insomnia.</p> <p>Resident #19 received Trazodone 8 times in November 2014, 1 time in December 2014 and 1 time in January 2015, all for complaints of insomnia. The effectiveness was documented with a circled plus sign and "eff" for "effective" ranging from 1 hour after administration to 1 hour and 45 minutes after administration.</p> <p>On 1/12/15 at 2:03 PM, the Administrator, DON and Unit Manager #1 were interviewed. The three staff members explained the rationale for using duplicate therapy was because Trazodone was used for insomnia, however monitoring hours of sleep did not occur except for some sleep studies conducted. The resident had a 1 on 1 while she was in her room, but that person did not monitor the number of hours Resident #19 slept.</p>	{F 329}	<p>Justification will be obtained from physicians when prescribing psychotropic medications for insomnia when a resident is receiving a scheduled psychotropic medication. Nursing documentation will be modified to monitor the effectiveness of PRN psychotropic medications for insomnia by documenting the duration of sleep a resident has after medication use. Ongoing inservicing will be done to ensure that staff is following new escalating behavior protocols and adequate monitoring of PRN medication effectiveness. Weekly audits beginning the week of 01/12/15 will be performed on all PRN psychotropic medications for one month and monthly for three months after that. The IDT team will then determine the frequency of further audits.</p>	

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{F 329}	<p>Continued From page 5</p> <p>Effectiveness of the medication was noted during first rounds and the Unit Manager said she thought the CNAs would report if the resident was not sleeping. When asked how the CNA would know to report if the resident was not sleeping but perhaps resting quietly, no answer was provided.</p> <p>Resident #19 was receiving 2 antidepressant medications, Lexapro and Trazodone without clinical justification. The Trazodone was administered as needed (PRN) for insomnia, but there were no guidelines as to when it was appropriate to administer the medication. In addition, hours of sleep were not monitored to determine effectiveness of that medication.</p> <p>On 1/12/15 at 4:45 PM, the Administrator and DON were informed of the duplicate therapy issues. No further information was provided.</p> <p>2. Resident #18 was admitted to the facility 10/15/14 with diagnoses of dementia unspecified with behavior disturbance, diabetes mellitus Type II and psychosis with paranoia.</p> <p>The initial MDS assessment, dated 10/21/14, documented the resident was</p> <ul style="list-style-type: none"> - severely cognitively impaired (BIMS =1) - multiple behaviors including verbal, physical, and "other" - minimal assistance of one staff required for transfers, dressing, personal hygiene, and eating. <p>The 12/1/14 physician's recapitulation order documented the resident was to receive "Ativan 0.5 mg - 1 mg orally or intramuscular daily as</p>	{F 329}	<p>4. The DNS or designee will follow this issue in QA review through weekly IDT meetings and report to the QA committee beginning 01/23/15. After three months, the QA committee will determine the need for ongoing monitoring.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 329}	<p>Continued From page 6</p> <p>needed [PRN] - breakthrough anxiety." This order was started on 11/20/14. The resident was also receiving a routine medication of "Ativan 0.5 mg orally three times a day [for] anxiety with behavioral disturbance."</p> <p>The routine medication was held for almost every dose the first 15 days of December 2014 and when the physician made rounds on 12/15/14, he discontinued the routine Ativan but not the "as needed" dosages. The physician failed to document the parameters the facility was to follow for administering the PRN 0.5 mg or 1 mg dosage of Ativan.</p> <p>The facility developed an "Escalating Behavior Protocol," which addressed three phases of Resident #18's identified behaviors. For phase two and three, one of the interventions was to administer "PRN medication." The intervention did not identify how much of the medication to administer, nor did it specify how many of the target behaviors the resident must exhibit to receive the medication.</p> <p>Resident #18 received Ativan four times in December 2014. On one occasion the resident received 1 mg and on three occasions, the resident received the 0.5 mg dosage. The resident received 1 mg of Ativan two times in the first 14 days of January 2015.</p> <p>The Administrator, DON and social service staff met with the surveyors on 1/12/15 at 3:30 p.m. Documentation was provided by the facility on the resident's behaviors and medication administration, however the information did not clearly articulate when nursing staff was to use the higher dose of Ativan. No other information</p>	{F 329}			

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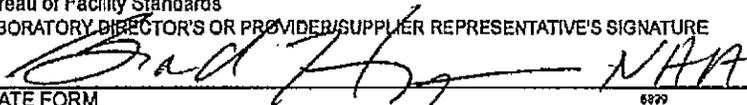
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{F 329}	Continued From page 7 was provided.	{F 329}			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/12/2015
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{C 000}	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the followup to the State Licensure survey of your facility. The surveyors conducting the survey were: Arnold Rosling RN, BSN, QIDP Lauren Hoard RN, BSN The survey team entered the facility on January 12, 2015 and exited on January 12, 2015.	{C 000}		
{C 782}	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F280 as it relates to revised care plans.	{C 782}	See F-280	01/13/15
{C 820}	02.201,01,a 30-Day Review of All Meds a. Reviewing the medication profile for each individual patient at least every thirty (30) days. The attending physician shall be advised of drug therapy duplication, incompatibilities or contraindications. This Rule is not met as evidenced by: Please refer to F329 as it relates to duplicative therapy and indications for medication usage.	{C 820}	See F-329	01/13/15

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NAA	(X6) DATE 2/3/15
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