



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

FILE COPY

February 26, 2015

Tobi L. Lucero, Administrator  
Bell Mountain Village & Care Center  
706 South Main Street  
Hailey, ID 83333-8400

Provider #: 135069

Dear Ms. Lucero:

On **February 12, 2015**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Bell Mountain Village & Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

In addition, a follow-up revisit to a Complaint Investigation survey of November 19, 2014, was conducted on February 12, 2015. Please see separate cover letter and CMS-2567 related to the facility not being in substantial compliance with federal regulatory requirements as a result of that survey.

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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion**

Tobi L. Lucero, Administrator  
February 26, 2015  
Page 2 of 4

**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 the 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 Plan of Correction (PoC) for the deficiencies must be submitted by **March 11, 2015**. Failure to submit an acceptable PoC by **March 11, 2015**, may result in the imposition of civil monetary penalties by **March 31, 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 **December 4, 2014**, following the **Complaint Investigation** survey of

Tobi L. Lucero, Administrator  
February 26, 2015  
Page 3 of 4

**November, 19, 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 **May 19, 2015**, if substantial compliance is not achieved by that time.

Please refer to the letter from CMS dated **December 5, 2014**, and any further communications from them that outlines recommended and/or imposed remedies related to the Complaint Investigation survey of November 19, 2014, and/or the Recertification, Complaint Investigation and State Licensure survey of February 12, 2015.

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

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Option #2, Fax #: (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. 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)

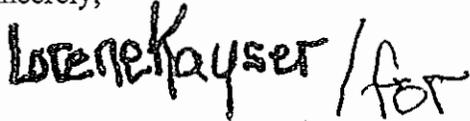
2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

This request must be received by **March 11, 2015**. If your request for informal dispute resolution is received after **March 11, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Tobi L. Lucero, Administrator  
February 26, 2015  
Page 4 of 4

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser" followed by a large, stylized "A" and "for" written below it.

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

DS/dmj  
Enclosures

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

PRINTED: 02/24/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>135069 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>02/12/2015 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>BELL MOUNTAIN VILLAGE & CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>706 SOUTH MAIN STREET<br>HAILEY, ID 83333 |
|---|--|

| (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         | INITIAL COMMENTS<br><br>The following deficiencies were cited during the annual federal recertification and complaint investigation survey of your facility.<br><br>The surveyors conducting the survey were:<br>Arnold Rosling RN, BSN QMRP, Team Coordinator<br>Brad Perry LSW<br><br>The survey team entered the facility on February 9, 2015 and exited on February 12, 2015.<br><br>Survey Definitions:<br>ABX = Antibiotics<br>ADON = Assistant Director of Nursing<br>BID = Twice a Day<br>BIMS = Brief Interview for Mental Status<br>cm = Centimeters<br>CNA = Certified Nurse Aide<br>DON/DNS = Director of Nursing/Services<br>L = Left<br>LN = Licensed Nurse<br>MAR = Medication Administration Record<br>MG = Milligram<br>MDS = Minimum Data Set assessment<br>NA = Nurses Aide<br>NN = Nursing progress note<br>PO = By Mouth<br>PRN = As Needed<br>R = Right<br>S/S = Signs and Symptoms | F 000 |   |         |
| F 151<br>SS=D | 483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL<br><br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.   | F 151 | F151 - All residents have been interviewed, during this interview it was found that some of the residents were notified of voting and some were not informed of voting dates and times. All | 3/10/15 |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br><i>Raw Luro</i> | TITLE<br>UHA | (X6) DATE<br>3-11-15 |
|--|--------------|----------------------|

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.

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| F 151 | <p>Continued From page 1</p> <p>The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on resident group interview and staff interviews, it was determined the facility failed to allow residents to exercise their rights as United States citizens when the facility failed to provide an opportunity for residents to vote in the November 2014 general elections. This affected 3 of 5 residents in the group interview. This practice created the potential to negatively affect the residents' psychosocial well-being if they were not allowed to exercise their rights as citizens. Findings included:</p> <p>On 2/10/15 at 2:00 PM, during the Quality of Life Assessment Group Interview, five residents attended the group interview and were asked if they voted in the November 2014 general elections. Three of the five said they had not voted and were not informed by facility staff of their voting rights.</p> <p>On 2/11/15 at 2:25 PM, the Activity Director was interviewed regarding voting. She said the former Social Services Designee (SSD) had been in charge of voting.</p> <p>On 2/11/15 at 2:30 PM, the SSD was interviewed and she said she had just been hired on 1/13/15 and did not know if residents were given the right to vote or not. She also said she did not believe the facility had documentation of whether residents declined their right to vote.</p> | F 151 | <p>residents desiring to exercise their right to vote, now have the choice to be driven to the voting polls or receive absentee ballots. Facility will make sure that the resident has the right to exercise his or her rights as a resident of the facility and as a citizen or residents of the United States. Each resident has the right to be free of interference, coercion, discrimination and reprisal from the facility in exercising his or her rights.</p> <p>Activities staff will incorporate voting into the Activities Calendar during all election times. Absentee Ballots will be offered for those desiring to vote by mail and Residents desiring to be driven to the Voting Polls will be identified and driven to the Voting Polls to cast their votes as they chose. All new admissions will be reviewed by the Activity staff in regards to their choice and exercising their rights to vote.</p> <p>Each election the Activities staff will Notify Residents about voting times and dates on the Activities Calendars, Resident Council, and during one to one Activities. To insure that elections and resident choices and rights are being exercised the activity calendars will be reviewed monthly by the Administrator and the Activity staff prior to that month.</p> |  |
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| F 151<br><br>F 156<br>SS=D  | <p>Continued From page 2</p> <p>On 2/11/15 at 5:00 PM, the Administrator and DON were informed of the issue. No further information was provided by the facility.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered</p> | F 151<br><br>F 156   | <p>The Administrator and Activities Director will follow up prior to election dates to ensure that all those desiring to exercise their right to vote have been identified and accommodated through Absentee Ballots or directly voting. This will be documented in the Residents chart every election by the Activity Staff to ensure that it did occur.</p> <p>F156 – Resident 21 and Resident 22 Medical Record were reviewed and due to the previous providers practices and forms it was confirmed that they did not receive adequate information on their “Notice of Medicare Non-Coverage” This has been rectified by creating new forms that include all the necessary information for contacting the fiscal intermediary. The Care Quality Team has been notified of the change of form change on 3/6/2015-</p> <p>All Residents receiving “Notice of Medicare Non-Coverage” will now have the new form that has the contact information of the fiscal intermediary.</p> <p>The new “Notice of Medicare Non-Coverage” forms have been updated and have replaced the previous Blaine Manor form that did not have the fiscal intermediary contact information.</p> | 3/10/15              |

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| F 156   | <p>Continued From page 3 under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:<br/>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and</p> | F 156  | <p>The Care Quality Review team will provide the new form to all Residents identified as in need of the issuance of the "Notice of Medicare Non-Coverage" This will be audited every week times four weeks times three months by the ADNS. This will also be reviewed by ADNS in QA, PPS and CQR for compliance.</p> |   |

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| F 156   | <p>Continued From page 4</p> <p>applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on staff interview and demand bill letter review, it was determined the facility failed to provide residents with enough information to contact the fiscal intermediary. This was true for 2 of 3 (#s 21 &amp; 22) residents reviewed. There was a potential for harm when a resident could not file a request for their stay to be reviewed. Findings include.</p> <p>Review of the "Skilled Nursing Facility Advanced Beneficiary Notice," dated 12/16/14, for Resident's #21 revealed there was no contact information on the form for the fiscal intermediary.</p> <p>Review of the "Notice of Medicare Non-Coverage," dated 11/30/14, for Resident #22 revealed there was no contact information in the form for the fiscal intermediary. There was a place on the form that documented, "{insert QIO name and Toll-free number of QIO}to appeal." The name and number was not on the form.</p> <p>The findings were presented to the Administrator and DON on 2/10/15 at 7:40 p.m. There was discussion that new letters were to be used and the letters found for Resident #s 21 and 22 were the previous edition, which had changed. No further information was provided.</p> | F 156  |   |                      |   |

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| F 226<br>F 226<br>SS=E  | <p>Continued From page 5<br/>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on review of the facility's abuse policies and procedures, staff personnel files and staff interviews, it was determined the facility failed to operationalize its abuse policies to ensure the provision of adequate abuse prevention training to five newly hired staff (#A,B, C, D, and E) and verification of abuse history with the State Nurse Aide Registry for 1 of 2 CNAs reviewed for abuse findings (#F). This practice created the potential to place residents at risk for abuse, neglect, and/or misappropriation of property. Findings included:</p> <ol style="list-style-type: none"> <li>1. The facility abuse policy and procedures under the section titled, Training, and dated July 2007, documented the following:<br/>"a. Employee Orientation will include education about abuse including identification, reporting and prevention. The Resident Services Director will be responsible for conducting the orientation regarding abuse issues including but not limited to:             <ol style="list-style-type: none"> <li>1. Appropriate interventions to deal with aggressive behavior.</li> <li>2. How staff will report knowledge or allegations of abuse without fear of reprisal</li> <li>3. How to recognize signs of burnout, frustration</li> </ol> </li> </ol> | F 226<br>F 226   | <p>F226 – The previous Policy and Procedures on abuse for new hires was a two page document of abuse acknowledgment that staff read and signed. Moving forward all new employees and existing employees were in- serviced about abuse. All new employees will be oriented and given training prior to working on the floor. All staff will be trained on all types of abuse, Abuse reporting, De-escalation of catastrophic reactions and aggressiveness by Residents, signs of burnout, frustration and stress that may lead to abuse. An in service regarding this was presented to all staff by the DNS on February 17, 2015 and on March 17, 2015 by the Administrator and Regional LCSW.</p> <p>The Policy and Procedures for the hiring process for new staff members that will include seven components: screening, training, prevention, identification, investigation, protection and reporting/response. Also all new staff members will be screened for past history of abuse through prior employers, State Nurse Aide registry, Idaho Professional licensing and other appropriate professional licensing boards.</p> | 3/10/15   |

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| F 226 | <p>Continued From page 6 and stress that may lead to abuse..."</p> <p>From 2/11/15 at 10:25 AM through 2/12/15 at 9:45 AM, Newly Hired Staff A through E were interviewed regarding abuse training and 4 out of 5 said they had not received an abuse orientation. The staff who said he/she had received training stated the training was a "broad overview." Another staff member said instead of abuse training, he/she was given a paper with types of abuse written on it and was asked to read it and sign the form.</p> <p>On 2/12/15 at 9:55 AM, the DON was interviewed regarding abuse training. She stated the CNA and nursing staff should have received training as part of their orientation. When asked who was responsible for the abuse training, she indicated it was the Business Office Manager (BOM) who conducted that training. When asked if the BOM was aware of her role as abuse trainer, the DON stated, "Hopefully she does."</p> <p>On 2/12/15 at 10:05 AM, the BOM was interviewed about abuse training. She appeared to be unaware of her role as the abuse trainer. She said she was responsible to give new employees an undated copy of a two page document titled, Abuse and Neglect Policy/Inservice. She said new employees were to read it and sign it upon hire. Note: The document did not contain information on how to deal with aggressive behavior, how staff were to recognize signs of burnout and stress and whether or not staff who reported abuse would be reprimanded.</p> <p>Guidelines at F226, documented:<br/>"II. Training (42 CFR 483.74(e)): Have</p> | F 226 | <p>New staff will not be allowed to work with residents until they have received the proper training regarding abuse and have been cleared from previous or employers or other applicable state agencies. A copy of findings documented and placed into each employee's personnel file, to include copies of licenses, certificates and reference checks.</p> <p>All newly hired staff will receive training from the Social Services Designee on dealing with Abuse, Aggressive Residents, de-escalation techniques, and proper reporting to if abuse is suspected. The revised Abuse Policy and Procedures will be signed off by the Social Service designee and a copy given to Human Resources to place in the employees file. Regular in services throughout the year will include two Abuse training beginning March 17, 2015 and on-going training on issues related to abuse prohibition practices. on appropriate interventions to deal with aggressive or catastrophic reactions of residents, how staff should report allegations without fear of reprisal, how to recognize signs of burnout, frustration and stress and what constitutes abuse, neglect and misappropriation of resident property</p> |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| NAME OF PROVIDER OR SUPPLIER<br><br>BELL MOUNTAIN VILLAGE & CARE CENTER |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>706 SOUTH MAIN STREET<br>HAILEY, ID 83333 |   |   |
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| F 226   | <p>Continued From page 7</p> <p>procedures to train employees, through orientation and on-going sessions on issues related to abuse prohibition practices such as:</p> <ul style="list-style-type: none"> <li>- Appropriate interventions to deal with aggressive and/or catastrophic reactions of residents;</li> <li>- How staff should report their knowledge related to allegations without fear of reprisal;</li> <li>- How to recognize signs of burnout, frustration and stress that may lead to abuse; and</li> <li>- What constitutes abuse, neglect and misappropriation of resident property."</li> </ul> <p>2. The facility abuse policy and procedures under the section titled, Screening, dated July 2007, documented the following:<br/>"All new employees will be screened prior to employment for a history of abuse, neglect or mistreatment...b. The Director of Nursing will contact the appropriate licensing boards and registries for each new employee..."</p> <p>On 2/12/15 at 11:20 AM, two nurse aide employee personnel files were reviewed for the State Nurse Aide Registry Verification Report. Staff F, who was hired on 12/23/14, had a copy of the report in her file, but it documented the date the facility checked the verification report was on 2/12/15, rather than prior to her hire date.</p> <p>On 2/12/15 at 1:10 PM, the BOM was interviewed. She said she could not find documentation the facility checked the registry prior to the employee's hire date and it was printed the day the surveyor asked for the documentation. Note: The verification report for Staff F, dated 2/12/15, did not document any abuse findings.</p> | F 226  | Administrator will review all new hires with the HR department every week times four weeks times three months.  |   |

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| F 226   | Continued From page 8<br>Guidelines at F226, documented:<br>"I. Screening (483.13(c)(1)(ii)(A)&(B): Have procedures to screen potential employees for a history of abuse, neglect or mistreating residents as defined by the applicable requirements at 483.13(c)(1)(ii)(A) and (B). This includes attempting to obtain information from previous employers and/or current employers, and checking with the appropriate licensing boards and registries."<br><br>On 2/12/15 at 2:15 PM, the Administrator, DON, and Regional Operations Director were informed of the issues. No further information was provided by the facility.   | F 226  |  |   |
| F 241<br>SS=E   | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, it was determined the facility failed to ensure assistance at meals was provided in a manner to maintain or enhance each resident's dignity when a staff member stood while assisting residents to eat. This was true for 1 of 9 sampled residents (#8) and 3 random residents (#s 23-25) during a meal observation. This deficient practice had the potential to cause a decrease in the residents' sense of self-worth. Findings included:<br><br>On 2/10/15 from 6:12 PM to 6:22 PM, during the | F 241  | F241 – Residents #8, #23, #24, and #25 were interviewed by SSD and LCSW, also their Medical Records were reviewed to ascertain if there were any decreases in their mood, or onset of new or increased behaviors after the survey. Prior to survey the facility did not have meal managers to observe appropriately in the dining room with all meals to insure that each residents dignity and respect in full recognition of his/her individuality is promoted at all times.<br><br>All residents that need extensive assistance with their dining were identified. Staff were in serviced 2/17/2015 by the DNS on techniques to properly serve and assist Residents | 3/16/2015   |

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

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| F 241   | Continued From page 9<br>dinner meal observation, six residents were sitting at four tables which had been pushed together. NA #1 stood up to help Resident #23 drink a nutritional supplement. NA #1 then walked and stood next to Resident #8 and assisted him with a bite of chicken. NA #1 then stood next to Resident #25 to assist him with his juice drink and then stood next to Resident #24 and assisted her with a bite of chicken. NA #1 sat down for a few minutes to assist the other residents at the table, but then stood up to help Resident #8 with his dinner and Resident #23 with her supplement again. Note: The Registered Dietitian and ADON were both observed watching the meal service at the time.  | F 241  | during mealtimes to preserve their dignity and respect their individuality and to maintain and enhance his/her self-esteem and self-worth and reminding staff that they cannot stand while assisting with meals.   |                      |   |
| F 248<br>SS=E   | On 2/12/15 at 2:15 PM, the Administrator, DON, and Regional Operations Director were informed of the observations. No further information was provided by the facility.<br>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES<br><br>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, group and resident family interview, and staff interview, it was determined the facility failed to provide an ongoing program of activities to include:<br>- A calendar of activities with variety built into the daily programs, and | F 248  | Management staff is monitoring meal times in the dining room for correct techniques while assisting the Residents with meals.<br><br>All meal time monitoring will be reported daily to the Administrator and/or DNS, for follow up and review. If certain staff require more training during assisted dining this will be provided by the DNS. A formal audit will occur three times a week times four weeks times three months by the DNS or designee.<br><br>F248 – Prior to survey the full time Activity Director was on FMLA and facility asked the PRN activity assistant to help out with the activity department until the return of the full time director. During an audit of the activity calendar it was noted that the calendars lacked variety and choice. The Facility Activity Calendar was reviewed with the Activities Director upon her return back to the facility and she had noticed the lack of variety and stated she would make sure that the next month | 3/10/2015            |   |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 248   | <p>Continued From page 10</p> <p>- A clear way to communicate upcoming activities, canceled activities, and/or delayed activities to residents.</p> <p>This was true for 5 of 5 residents who attended the group meeting, and had the potential to affect most residents in the facility. This created a potential for psychological harm when residents were provided a lack of different activities, which potentially could create an atmosphere of boredom and foster an increase in negative behaviors. Findings included:</p> <p>1. The Activity Calendars for January and February 2015 were reviewed. The calendars lacked variety and were identical, with the exception of the Monday nights in January, which had an activity of "NFL Game" at 6:30 PM.</p> <p>The January and February 2015 activities were:<br/>         *Sunday: 10:00 AM-Daily News &amp; Service (church), 10:30 AM-One On One, 12:00 PM-Spiritual Visit, and 8:00 PM-Movie Time;<br/>         *Monday: 10:00 AM-Daily News, 11:30 AM-Exercise, and 3:00 PM-Snack Time;<br/>         *Tuesday: 10:00 AM-Daily News, 11:30 AM-[Performer Name]'s Guitar, 3:00 PM-Snack Time, 4:00 PM-Games, and 8:00 PM-Movie night;<br/>         *Wednesday: 10:00 AM-Daily News, 11:30 AM-Exercise, 3:00 PM-Snacks, 4:00 PM-Games, and 8:00 PM- Musicals;<br/>         *Thursday: 10:00 AM-Daily News, 11:30 AM-One On One, 1:30 PM-Pet Therapy, 3:00 PM-Tea Party, 4:30 PM-Exercise, and 8:00 PM-Comedy;<br/>         *Friday: 10:00 AM-Daily News, 11:30 AM-One On One, 3:00 PM-Rootbeer Floats, and 4:00 PM-Mystery Movie; and,<br/>         *Saturday: 10:00 AM-Daily News &amp; One On One, 11:30 AM-Sports, 3:00 PM-Snacks, and 8:00 PM-Lawrence Welk.</p> | F 248  | <p>calendar had variety and resident choice. New calendar was developed in March to meet the needs of all Residents interests and is not replicated month to month.</p> <p>All staff were in serviced on 3/10/2015 by the Activity Director about the importance of Activities and that the entire staff is responsible for notifying Residents of upcoming Activities, and all staff are responsible for assisting residents to the Activities of interest of each Resident. Another follow up staff training occurred on 3/17/2015 given by DNS and NHA.</p> <p>The Activities Department will meet with the Administrator on a monthly basis to review the Activity calendar for the upcoming month. This will ensure that calendars are not duplicated, staff are informing Residents of Activities and Residents interests are met. Canceled events will be highlighted on the Facility calendars to notify other staff and Residents. If possible a new activity will be offered. The facility has hired a dedicated van driver so it does not take Activities staff away from the facility.</p> |   |

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| F 248   | <p>Continued From page 11</p> <p>During the group interview on 2/10/15 at 2:00 PM, residents were asked about the activities offered. All five residents said the activities lacked variety and needed more selection. Two other residents said they would like to hear about current news events and when asked if the 'Daily News' activity covered current events, none of the residents were aware there was even a news activity (see additional information in #2 below). They all indicated they looked forward to Tuesdays, because they enjoyed the guitar music activity.</p> <p>On 2/12/15 at 8:15 AM, a resident's family member was interviewed. The family member said the activity calendar lacked a variety of appealing options for all of the age groups in the facility.</p> <p>On 2/12/15 at 11:00 AM, the Activity Director was interviewed. When asked to review the January and February activity calendars, as well as the apparent lack of variety, she stated there was, "Not a lot." She said she was out of the facility on leave when those calendars were developed and the person who developed them was currently out of the facility on leave.</p> <p>2. During the group interview on 2/10/15 at 2:00 PM, residents were asked how they were informed about the activities.</p> <p>-One resident said there was a large activity calendar near the nurses station and a white dry erase board across from it, which displayed that day's activities.</p> <p>-3 out of 5 residents in the group said they all had activity calendars in their rooms, but they could not read the small font on the paper. The surveyor produced an 8 1/2 by 11 inch calendar</p> | F 248  | <p>The Resident Council will meet with the Activities Director and/or the Administrator to discuss the changes they would like to see and needs they would like accommodated by the Activities department and other staff. Monthly, the QA will monitor the success of the Activities program and Resident Council concerns. Recreation assessments will be completed on admit and reviewed quarterly with MDS interventions. A formal audit will be conducted during CQR by Activity Director Weekly times four weeks' times three months.</p> |   |

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| F 248   | <p>Continued From page 12</p> <p>and they indicated their copies were the same size and that they had trouble reading the calendar.</p> <p>-Another resident said he/she attempted to attend the 'Comedy' activity on 2/5/15 at 8:00 PM and had looked forward to it, but could not find it. The resident said he/she looked in the activity room, the dining room, and the TV room. The resident also asked staff members about the activity, but they did not know about it.</p> <p>-4 out of 5 residents said the facility needed to better inform the residents of canceled activities and what the activities were each day. They suggested they would like to be informed at breakfast each day of what activities were going to be offered.</p> <p>On 2/11/15, prior to the scheduled 10:00 AM 'Daily News' activity, the following observations were made:</p> <p>-9:55 AM- No activity staff in the hallway, TV room, or dining room. No other staff members were observed to assist residents to the activity. The white dry erase board documented, "10:00 AM Daily News";</p> <p>-9:57 AM- The Activity Director and CNA #3 were observed walking down the hallway past the Administrator's office. The Activity Director then went into Resident #17's room and CNA #3 continued down the hallway to the nurses station;</p> <p>-10:00 AM- CNA #3 was observed talking to a resident near the nurses station, but did not mention anything about an upcoming activity;</p> <p>-10:02 AM- The Activity Director approached the white board and erased the 'Daily News' activity and then walked away down the hall; and,</p> <p>-10:10 AM- Resident #17 was observed in her room and was asked if the Activity Director spoke to her about an upcoming activity or about a</p> | F 248  |   |                      |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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| F 248   | <p>Continued From page 13</p> <p>canceled activity and she said their conversation was unrelated to activities.</p> <p>On 2/11/15, prior to and during the scheduled 11:30 AM 'Exercise' activity the following observations were made:</p> <ul style="list-style-type: none"> <li>-11:24 AM- No activity staff were observed in the hallway, TV room, or dining room. No other staff members were observed to assist residents to the activity. The white dry erase board documented, "11:30 AM Exercise";</li> <li>-11:33 AM- CNA #4 and NA #5 returned to the nurses station from a break. CNA #4 told NA #5 the residents did not have anything to do until lunch time, so they would check on call lights and the residents, then after that they would help residents to the dining room for lunch;</li> <li>-11:40-11:43 AM- The Activity Director and Assistant were observed asking residents if they would like to go to exercises;</li> <li>-11:50 AM- The 'Exercise' activity was in the dining room, which consisted of two residents and the Activity Director and Assistant; and,</li> <li>-12:02 PM- The 'Exercise' activity ended.</li> </ul> <p>On 2/12/15 at 11:00 AM, the Activity Director was interviewed. When asked how residents were informed of the activities, she said staff told residents about activities, used the large calendar and white board near the nurses station, and also provided residents individual calendars for their rooms. When informed about resident group concerns regarding the size of the calendars, she said she was out on leave when the January and February 2015 calendars were made and distributed and in the past she had used 11 by 17 inch paper to put in resident rooms. She provided the surveyor a copy of the January 2014 calendar as an example of the larger paper and font.</p> | F 248  |   |                      |   |

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| F 248   | Continued From page 14<br>When informed about a resident who could not find the 'Comedy' activity and what that meant, she said she assumed it was a comedy movie, she was not sure why it did not occur, and acknowledged the description of the activity was not clear. When asked why the 2/11/15 'Daily News' was canceled, she said she was one of the van drivers and she had to drive a resident to an appointment at that time and so the activity was canceled. When asked how often this occurred, she said, "Not often," because the facility had two other staff members who shared van driving duties. She also acknowledged residents were not informed the activity had been canceled. When asked why the 2/11/15 'Exercise' activity was started late, she said a resident's appointment had run late, which made her late driving the van back to the facility. | F 248  |  |                      |   |
| F 252<br>SS=E   | 483.15(h)(1)<br>SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT<br><br>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, it was determined the facility failed to ensure a home like environment when medications were   | F 252  | F252 – Residents #1, #3, #8, #13, #14, #15, and #24 Medical records were reviewed to determine if there were orders from an MD for dispensing medications during meal times. This was found to be the practice of the previous facility's to administer medications during mealtimes in the dining room. On 3/9/15 the CEO in-served all management about new procedure for inputting orders and monitoring. | 3/9/2015             |   |

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

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| F 252   | <p>Continued From page 15</p> <p>administered in the dining room while the residents were eating their meals. This had the potential to interfere with the meal consumption or socialization for all residents who ate in the dining room including 7 of 17 (#s 1, 3, 8, 13, 14, 15, &amp; 24) residents.. Findings include:</p> <p>On 2/10/15 during the lunch meal, the following was observed:</p> <ul style="list-style-type: none"> <li>- Resident #24 received digoxin at 12:45 p.m. while she was eating her lunch.</li> <li>- Resident #1 received sulcrafate while she was eating her lunch.</li> <li>- Resident #15 received lactobacillus while she was eating her lunch.</li> </ul> <p>On 2/10/15 during the dinner meal the following was observed:</p> <ul style="list-style-type: none"> <li>- Resident #13 received 4 medications, including Tums, which would be more effective after the meal.</li> <li>- An RN attempted to give Resident #3 four medications while he was eating. He initially refused, however the RN came back 15 minutes later and the resident took the medications.</li> <li>- Resident #8 received one medication while he was eating. The medication was ordered to be given when he was going to bed but was given during the meal.</li> <li>- Resident #14 received two medications while she was eating her dinner.</li> </ul> <p>On 2/12/15 at 9:00 a.m., the RD and RN#1 were interviewed about administering the medications during the meal. The RD indicated she did not feel it was appropriate. She said she made suggestions when she started consulting at the facility and no changes were made. RN#2 stated, there were standing orders from the physician to</p> | F 252  | <p>All Active Residents Medical Records were reviewed and updated to reflect the current standard of practice, "No medications to be dispensed in the dining room". Medications may be delivered during meal times in the residents rooms. DNS will audit this three times a week times four weeks times three months.</p> <p>The DNS or designee will review all orders five times a week times four weeks times three months. This will ensure that this does not occur again.</p> <p>On 3/9/2015 the CEO in serviced the department heads about who is to review orders and who is to input the orders.</p> |                      |   |

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

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| F 252   | Continued From page 16<br>give medications in the dining room. When asked to produce those orders, the surveyor was informed they were not available.  | F 252  |  |                      |   |
| F 253<br>SS=E   | On 2/12/15 at 1:30 p.m. the Administrator and DON were informed of the issues. No further information was provided by the facility.<br>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, it was determined the facility failed to ensure a bowel movement (BM) was removed from a resident bathroom floor and a door kick plate did not separate from the small kitchen door. This was true for 2 of 9 (#s 3 & 8) sampled residents, 1 random resident (#26) and had the potential to impact any resident ambulating past the small kitchen door. This had the potential to affect residents and decrease the quality of life of residents who used or frequented these areas. Findings included:<br><br>1. On 2/9/15 at 10:37 AM, 10:40 AM, 1:22 PM, and 3:35 PM, a large piece of feces was observed on the bathroom floor in front of the toilet shared by Residents #3, #8, and #26.<br><br>On 2/9/15 at 3:40 PM, LN #2, who was responsible for keeping resident rooms and bathrooms clean, said the housekeeping | F 253  | F253 – Residents #3 and #8 and #26 had their Medical Records reviewed to see if there were any subsequent issues with care related to the soiled bathroom floor. No issues were identified attributable to the soiled floor. During current audit it was noted that there had not been adequate housekeeping rounding and audits.<br><br>The DNS will conduct random audits three times a week times four weeks times three months. All staff will notify housekeeping if any unsanitary conditions are noted in Resident rooms or common areas immediately. | 2-27-2015            |   |

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

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OMB NO. 0938-0391

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| F 253   | Continued From page 17<br>department cleaned in the morning, but the nursing staff were responsible to alert housekeeping of areas of concern after that. LN #2 was then shown the feces on the floor and stated, "I will get housekeeping in here right now."<br>Note: The BM was observed to be removed within 15 minutes of LN #2 observation.<br><br>On 2/11/15 at 5:00 PM, the Administrator and DON were informed of the issue. No further information was provided by the facility.<br><br>2. On 2/12/15 at 10:45 AM, the small kitchen door next to the dining room was observed with a foot-long section of the door kick plate separated from the door, which created a quarter inch to 3 inch gap.<br><br>On 2/12/15 at 10:50 AM, the Administrator was shown the door and she said it must have come unglued. She immediately contacted the maintenance supervisor to fix the door. Note: The door was fixed by 2:00 PM the same day. | F 253  | The Administrator will conduct Administrative Grand Rounds weekly in the entire facility to insure State and Federal regulations are being applied. Monthly housekeeping performance will be included in the facility QA.<br><br>On 2-12-15 the door was fixed and up to code these items are part of the Administrative Grand Rounds. |                      |   |
| F 276<br>SS=D   | 483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS<br><br>A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, it was determined the facility failed to complete a quarterly assessment when due. This was true for 1 of 9 (# 16) sampled residents. There was a   | F 276  | F276 – Resident #16's Medical Record was reviewed and the MDS with all necessary reviews and assessments were completed and transmitted on 3/11/15.<br><br>To ensure that a missed quarterly assessment for any other Resident does not occur: Staff involved with the Assessment process now receive an updated MDS schedule, weekly. | 3-11-15              |   |

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| F 276   | Continued From page 18<br>potential for harm if new or changing resident conditions were not assessed, documented, care planned, or treated as a result of the missed quarterly assessment. Findings include:<br><br>Resident #16 was admitted to the facility on 10/1/14 with diagnoses of aftercare for a fractured right hip and chronic airway obstruction.<br><br>The facility completed an admission assessment on 10/8/14 and were scheduled to complete a quarterly assessment the first week of 2015; this assessment was not completed.<br><br>On 2/12/15 at 10:30 a.m. said she had been the MDS coordinator for about two weeks and was not aware there was an assessment not completed on the resident.<br><br>The Administrator and DON were informed of the issue on 2/12/15 at 1:30 p.m. No further information was provided by the facility. | F 276  | Follow ups will be done by the DNS to make sure that every MDS, care plan, notes, or Assessments are completed, updated, and transmitted.<br><br>The DNS will monitor the MDS process and provide support to the MDS Coordinator to ensure that all MDS's are scheduled accordingly.<br><br>DNS will audit weekly during CQR meetings with MDS Coordinator weekly times 4 weeks times 3 months and daily during MDS PPS meetings Monday through Friday X 4 weeks times 3 months. |                      |   |
| F 280<br>SS=D   | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>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 changes in care and treatment.<br><br>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,  | F 280  | F280 – Resident #14 Medical Record was reviewed and all necessary care plans updated to reflect her current needs.<br><br>All Residents Medical Records were reviewed to insure that the care plans accurately reflected their needs. With documentation to confirm the need for any care plan revisions.  | 3-10-15              |   |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 280 | <p>Continued From page 19</p> <p>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:<br/>Based on staff interview and record review, it was determined the facility failed to revise a care plan for 1 of 9 sampled residents (#14). The care plan did not reflect revisions for a resident's toileting needs. This had the potential to result in harm if residents did not receive appropriate care due to lack of direction in the care plan. Findings included:</p> <p>Resident #14 was readmitted to the facility on 7/18/14 with multiple diagnoses including urinary incontinence.</p> <p>The resident's 7/18/14 Urinary Incontinence care plan documented the resident had, "Frequent episodes of urinary incontinence..." and documented an intervention to, "Encourage resident to call for assistance with toileting..."</p> <p>The resident's 7/26/14 annual MDS assessment documented the resident was frequently incontinent of urine.</p> <p>The resident's 1/20/15 quarterly MDS assessment documented the resident was occasionally incontinent of urine.</p> <p>On 2/12/15 at 10:30 AM, the ADON said the</p> | F 280 | <p>The DNS and MDS case manager will regularly review Resident care plans. At least quarterly the Interdisciplinary Team will conduct care conferences to include the Resident and any interested family or friends. At this time the chart will be reviewed for accuracy and completeness again.</p> <p>The care planning process will be reviewed with each MDS ARD, and/or upon a change of condition for each Resident. Monthly, the MDS and care planning will be included in the facility QA program.</p> <p>DNS will audit weekly during CQR meetings with MDS Coordinator weekly times 4 weeks times 3 months and daily during MDS PPS meetings Monday through Friday X 4 weeks times 3 months.</p> |  |
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| F 280   | Continued From page 20<br>resident was not on a toileting plan, but was toileted more frequently and stated, it's "not reflected here," and pointed to the care plan. She said she knew some of the care plans had not been revised.<br><br>On 2/12/15 at 2:15 PM, the Administrator, DON, and Regional Operations Director were informed of the issues. No further information was provided by the facility.   | F 280  |  |                      |   |
| F 314<br>SS=G   | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, it was determined the facility failed to ensure that residents did not develop pressure ulcers while residing in the facility. This was true for 2 of 10 (#s 16 & 20) sampled residents. Resident #20 was harmed when a sore on the coccyx progressed to a Stage III pressure ulcer, and Resident #16 was harmed when a red area previously identified as a Stage I pressures ulcer deteriorated to a Stage II pressure ulcer. Findings include: | F 314  | F314 – During an audit it was discovered that pressure sores were developed in the facility. Resident #20 has been discharged from the facility on December 9, 2014. Resident #16 has had her pressure sore resolved, we are currently using barrier cream to her buttocks, monitoring her coccyx every shift, her Head of bed <30 degrees. We are turning every two hours. She is up for meals only. Her right heel is in a Prevalon boot and we are floating her heel with a pillow. She currently has an air mattress.<br><br>The facility instituted assessing all skin at risk by the DNS or Designee and wound nurse. The licensed nurse will complete a head to toe skin assessment within 24 hours of admit to identify skin | 3-23-15              |   |

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

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| F 314   | <p>Continued From page 21</p> <p>1. Resident #20 was admitted to the facility 12/5/10 with diagnoses of Alzheimer's Disease, dementia without behavior disturbances, and depressive disorder.</p> <p>The most recent quarterly MDS, dated 10/3/14, documented the resident:</p> <ul style="list-style-type: none"> <li>- had short and long term memory impairment.</li> <li>- had severely impaired decision making skills.</li> <li>- required extensive assistance with ADLs.</li> <li>- did not have a pressure sore.</li> </ul> <p>The resident's care plan, dated 11/13/14, documented:<br/>"Problem Onset 11/13/2014, Pressure ulcer to coccyx."</p> <p>Interventions included:</p> <ul style="list-style-type: none"> <li>** Milkshake q {every} day.</li> <li>* Clean open area @ buttocks with MicroKlenz, apply Bacitracin/zinc to wound bed. Apply barrier/zinc cream to periwound area, BID or when soiled.</li> <li>* Head of the bed less then 30 degree, turn every 2 hrs, roho seat cushion, low air mattress, up for meals only.</li> <li>* Weigh resident weekly &amp; record.</li> <li>* Bell Mountain wound and skin protocol.</li> <li>* Turn side to side Q {every}2 hours.</li> <li>* Air mattress overlay.</li> <li>* Up for meals only.</li> <li>* Wound clinic visits, per clinic recommendation.</li> <li>* Tylenol is prescribed.</li> <li>* Measure wound at least Q 7 days. Record HxWxL, appearance, amount and odor of any drainage. Record on Pressure Ulcer Log. Report any decline in wound status to physician.</li> <li>* Administer treatments as ordered by physician and document.</li> </ul> | F 314  | <p>integrity problems that occurred prior to admission. All new admissions will receive an assessment to predict pressure sore risk using the Braden Scale Assessment and an intervention tool to provide interventions to help prevent development of pressure sores. The accuracy of the Braden scale assessment will be confirmed weekly times 4 weeks for one month then twice a month for two months audited by an interdisciplinary team during Skin and Weight Review Meeting. All Braden Scale Assessments will be done on a quarterly basis or as needed thereafter.</p> <p>All Residents at Risk for Impaired Skin Integrity will be logged into a Monthly "At Risk for Impaired Skin Integrity Log". This log will assist in keeping the facility current with information pertaining to residents who do not have a pressure sore but who have been identified as at risk for pressure sore development.</p> <p>The facility will request a screening for seating and positioning needs to be completed by a skilled therapist for all residents determined to be at risk for impaired skin integrity. Seating and positioning screens will be completed following admission and repeated quarterly. Any individual identified as incontinent will be placed on a specific</p> |                      |   |

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| F 314   | <p>Continued From page 22</p> <ul style="list-style-type: none"> <li>* Administer pain medication at least 30" {minutes} prior to initiating treatment as indicated.</li> <li>* If no improvement in wound appearance by 10 days after treatment order changed, notify physician and request new treatment order.</li> <li>* Dietitian to evaluate and follow up at least weekly.</li> <li>* Provide diet high in protein, with and in between meal snacks.</li> <li>* Monitor labwork and report to physician and dietitian when available.</li> <li>* Record food intake % at each meal. Report any decline to physician and dietitian.</li> <li>* Offer food substitutes if resident refuses to eat.</li> <li>* Use pillows, air mattress, other supportive/protective devices to assist with positioning.</li> <li>* Avoid use of restrictive clothing.</li> <li>* Cleanse perineal area following each bowel movement.</li> <li>* Turn and position resident every 2 hours. Side to Side.</li> </ul> <p>Review of the resident's progress notes for several months prior to 11/12/14 revealed the resident was dependent on staff for all ADLs and was incontinent of bowel and bladder. The progress notes documented:</p> <ul style="list-style-type: none"> <li>- 11/12/14 WOUND/SKIN RECORD "Date:11/12; Site: A {right buttock/coccyx}; Stage: N/A; Size in CM (length x width): 3 cm x 3 cm; Depth (cm): SF {superficial}; Exudate: SS {serosanguinous} with crevice wound; Odor: none; Wound bed: red; Surrounding tissues: Flat uneven..."</li> <li>- 11/14/14 at 2:44 am Nurse Note {NN}, "Open area @ R buttocks, 3cm /3cm, 0 S/S of infection. RN to clean and apply Meplex..."</li> <li>- 11/16/14 3:43 pm NN "The dressing has come off with incontinence moisture. I have cleaned it</li> </ul> | F 314  | <p>bowel and bladder program. This program will be reviewed weekly times four weeks times 3 months by the DNS or Designee to ensure that staff are following the program as developed.</p> |                      |   |

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| F 314   | <p>Continued From page 23</p> <p>with NS and applied ABX {antibiotic} ointment...He is last up and first down and resting 30 degree lateral side to side while in bed..."</p> <p>- 11/17/14 12:53 pm NN "Checked resident's bottom this morning. Area appear to be 1.5 cm x 1.5 cm wound. {Name}, DNS, assessed wound and said it appeared to be a moisture wound rather that a pressure wound. Wound is clean and barrier ointment was applied to area. Resident is currently on right side. He is turned every 2 hours and is last up, first down to prevent sore on the area..."</p> <p>- 11/18/14 9:52 am NN "...Buttock wound assessed. Noted an area approx 2cm x 2cm to gluteal cleft with a geographical appearance, superficial and an area within the wound which is approx 0.5 x 0.3 cm crevice wound. Area does not rest on a bony prominence and appears to be related to moisture. Resident is incontinent of Bowel and bladder despite regular toileting..."</p> <p>- 11/19/14 WOUND/SKIN RECORD "Date: 11/19; Site: A {right buttock/coccyx}; Stage: 2; Size in CM (length x width): 2.5 x 2; Depth (cm): 0.3; Exudate: Scant blood and slough; Odor: none; Wound Bed: red slough, Surrounding skin color: Purple/ Blanches; Surrounding Tissue/wound edges: Irregular"</p> <p>- 11/21/14 Wound Clinic Progress Note, "CHIEF COMPLAINT: The patient is seen for an ulceration on his coccyx... HISTORY OF PRESENT ILLNESS: ...The patient's history is given by the patient's wife which includes a 10 day history of developing an ulceration in the coccyx region...is incontinent of both bowel and bladder...he is on a standard mattress. Just recently has been turned every 2 hours, does not have a ROHO seat cushion but has a very thin cushion in his adjustable, non-motorized wheelchair...SKIN AND WOUND: Examination of</p> | F 314  |   |   |

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

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OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>135069  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____               |   | (X3) DATE SURVEY COMPLETED<br><br>C<br>02/12/2015 |
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| F 314   | <p>Continued From page 24</p> <p>the coccyx reveals an area of ulceration measuring 2.0 x 1.7 x 0.1 cm. There is no tunneling or undermining. The periwound tissue is erythematous with indistinct wound margins and wound base 100% fibrin and slough. The exudate was unable to be determined due to being open to air. There was no odor...IMPRESSION:<br/>1. Stage II pressure ulceration of the coccyx area..."</p> <p>- 11/24/14 10:53 am NN "...Late entry for 11-23-14. Resident positioned on his side this AM and was noted to have his head and left shoulder hanging over the side. Air mattress overlay requires very careful positioning of this resident who tends to grab nearby furniture and pull himself to the edge of the bed. It happened again later in the shift. The air mattress is slippery and side lying requires close monitoring. {sic}... His coccyx area has slough in the center of it and clean margins. Wound care done twice this shift. He continues as 'last up-first down.' ...With his grabbing behaviors, peri-care while lying in bed is more difficult than doing it while he is occupied with holding onto the EZ lift and standing but while standing he can make his buttocks very tight and careful cleaning is not easy."</p> <p>- 11/26/14 WOUND/SKIN RECORD "Date: 11/26; Site: A {right buttocks/coccyx}; Stage: 2; Size in CM: 2 x 2 ; Depth: 0.3; Exudate: none; Wound bed: Slough; Surrounding skin color: White; Surrounding tissue: Irregular, clean;"</p> <p>- 11/27/14 4:06 pm NN "...Resident is extremely difficult for staff to reposition, dress or transfer due to res stiffens and pushes against staff and grabs staff and his grasp is very strong. Requires at least two people for this....Incontinent of bowel and bladder..."</p> <p>- 11/30/14 2:31 pm NN "He continues as 'last up-first down for meals' some meals he has had</p> | F 314  |   |   |

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| F 314   | <p>Continued From page 25</p> <p>while on bedrest. Airbed overlay continues and he has padded half bed rails for safety/grabbing behaviors (as in he grabs furniture and risks pulling himself out of bed) He usually has some stooling, ...open area which continues (sic) to have depth..."</p> <p>- 12/1/14 Wound Clinic Progress Note, "CHIEF COMPLAINT: Patient is seen today for a stage 2 pressure ulceration on the coccyx...SKIN AND WOUND: Examination of the coccyx reveals an area of ulceration measuring 3.6 x 2.0 x 1.0 cm. There is tunneling at 12 o'clock at 0.5cm and at 6 o'clock at 0.5 cm. There is no undermining. Periwound tissue is minimally erythematous with defined wound margins. The wound base is 80% granulation and 20% fibrin slough. There is a scant amount of serosanguineous exudate with no odor. periwound tissue is still blanchable, although it has a purple discoloration. There is necrotic tissue evident at the base of the wound. although I cannot visualize bone, I can probe to bone. There is no induration felt in the periwound area or fluctuance.... IMPRESSION: 1. Stage 4 pressure ulceration of the coccyx area... PLAN/DISCUSSION:...The wound has deteriorated from a Stage II pressure ulcer to a Stage IV pressure ulcer since his last visit with unknown cause...."</p> <p>- 12/3/14 WOUND/SKIN RECORD "Date: 12/3; Site:A {right buttocks/coccyx}; Stage: IV; Size in CM: 3.6 x 2; Depth: 1.0; Exudate: none; tunneling: none; Odor: none; Wound bed: Pink; Surrounding skin color: pink"</p> <p>The wound nurse was interviewed on 2/11/15 at 12:20 p.m. and stated the resident was a very tall person and the staff had a hard time cleaning him up after an incontinence episode. They started to use the stand assist lift to stand him to change</p> | F 314  |   |                      |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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| F 314   | <p>Continued From page 26</p> <p>his briefs. He would tighten his buttocks so that cleaning him was difficult. The "staff couldn't do a good job of cleaning him." As a result, "He had moisture issues and he ended up with a sore." She further indicated that she was working with staff on turning, positioning and body alignment, and stated the new DON wanted her to start using the Braden Scale for skin assessments.</p> <p>At the time of survey, the resident was no longer in the facility and observations of the pressure ulcer were not possible. The resident was harmed when:</p> <ul style="list-style-type: none"> <li>- he developed a Stage II pressure ulcer that deteriorated to a Stage IV pressure ulcer.</li> <li>- the facility did not give the resident an air mattress until after the area developed into a Stage II ulcer.</li> <li>- the facility was not aggressive in cleaning and keeping urine and stool off the residents skin.</li> <li>- The facility did not have a 4 inch ROHO for the resident's wheelchair.</li> </ul> <p>2. Resident #16 was admitted to the facility on 10/1/14 with diagnoses of after care surgery of right hip fracture and chronic airway obstruction.</p> <p>The admission MDS assessment, dated 10/8/14, documented the resident:</p> <ul style="list-style-type: none"> <li>- Was cognitively intact with a BIMS of 15.</li> <li>- Required extensive assistance with ADLs.</li> <li>- Was occasionally incontinent of bowel and bladder.</li> <li>- Had a pressure sore on the heel.</li> </ul> <p>The resident was admitted to the facility with a possible pressure sore to the right heel and red area to the coccyx. The area on the coccyx was documented as possibly a healed Stage II</p> | F 314  |   |   |

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| F 314 | <p>Continued From page 27</p> <p>pressure sore the physician identified in the 9/4/14 operative report. The coccyx was monitored until it deteriorated again on 12/12/14. Summary of the care provided to the coccyx area follows.</p> <p>The resident's Care Plan, dated 10/1/14, documented: "Problem: Pressure ulcer to R Heel, present on admission, unstageable on admission/debrided. Redness to coccyx on admission." The resident's interventions for the coccyx included:</p> <ul style="list-style-type: none"> <li>"* Monitor redness to coccyx each shift until resolved."</li> <li>"* Administer treatments as ordered by physician and document."</li> <li>"* Record food intake % at each meal. Report any decline to physician and dietitian."</li> <li>"* Offer food substitutes if resident refuses to eat."</li> <li>"* Use pillows, air mattress, other supportive/protective devices to assist with positioning."</li> <li>"* Avoid restrictive clothing."</li> <li>"* Cleanse perineal area with soap and water following each bowel movement."</li> <li>"* Turn and position resident every 1 - 2 hours as indicated by individual turning schedule posted in resident's room."</li> <li>"* Teach resident risk factors for development of pressure ulcers as appropriate."</li> </ul> <p>On 12/10/14 the intervention, "Gel Mattress to bed," was added to the Care Plan.</p> <p>The physician's admission orders, dated 10/10/14, documented:<br/>"Monitor redness to coccyx q shift until resolved."<br/>"Airbed overlay for skin protection."</p> | F 314 |  |  |
|-------|--|-------|--|--|

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 314   | Continued From page 28<br>On 12/10/14 the air mattress overlay was discontinued and a "Gel Mattress" was ordered. On 12/12/14 the resident was complaining of a sore bottom and a 1 cm open area was found on the right buttock. The resident was seen the same day, 12/12/14, in the wound clinic, which documented, "Stage II ulcer coccyx." The wound clinic ordered, "Head of bed less than 30 degrees, turn every two hours, low air loss mattress, and up for meals only."<br><br>The wound nurse was interviewed on 2/11/15 at 12:20 p.m. She indicated the resident would need to ask for staff to look in on her and that since she has been providing the wound care she has advocated for staff to go in and check and change the resident, especially on the night shift. The wound nurse also noted she had been training staff on positioning and body alignment. No further information was provided. | F 314  |   |                      |   |
| F 315<br>SS=G   | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate   | F 315  | F315 An audit was conducted and it was discovered that we had an issue with infections with one resident with a catheter. This issue was addressed in our Quality Assurance meeting and policies have been revised to decrease risk to our resident's with catheters. | 3-23-15              |   |

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| F 315   | <p>Continued From page 29</p> <p>treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, staff interview, record reviews, and policy review, it was determined the facility failed to:<br/>Ensure a resident (# 8) with a catheter received services to protect against catheter-related complications; and<br/>Ensure that residents (# 13, 14, &amp; 16) who were incontinent of urine, received care and services to improve their level of continence.<br/>This was true for 4 of 9 (#s 8, 13, 14, &amp; 16) sampled residents. Resident #8 was harmed when alterations in treatment caused the resident to become septic and require admission to the hospital. Findings include:</p> <p>1. Resident #8 was admitted to the facility on 9/21/14, and readmitted on 1/19/15, with diagnoses of dementia with behavior disturbance, Alzheimer's Disease and Benign Prostatic Hyperplasia.</p> <p>The 10/4/14 admission MDS documented the resident:<br/>- Had short and long term memory impairment.<br/>- Required assistance with ADLs.<br/>- Had a foley catheter.<br/>- Received an antibiotic 7 days a week.</p> <p>The 9/21/14 care plan documented "Infection: Admitted with urinary tract infection evidenced by lab report indicating organism. Risk for infection related to catheter, overall condition." The care</p> | F 315  | <p>Resident #8 chart was audited and it was noted that THAT Keflex 250mg PO QHS was started on 1/23/2015 and continued until resident discharged on 2/24/2015. Resident received H2O while awake as ordered. He had no signs and symptoms of infection when discharged on 2/24/2015. All orders will be double checked for accuracy by DNS or designee. On 2/17/2015 all nursing staff were in-serviced by DNS on catheter care.</p> <p>Bell Mountain Village has instituted new catheter procedures, this policy includes daily catheter care, weekly catheter care procedures. Procedures on changing catheter bag and procedures to enhance prevention of urinary tract infections.</p> <p>Training has been provided on policies by the DNS on 3/17/2015 and will be reviewed again on 3/30/2015.</p> <p>This procedure will be audited by the DNS or designee three times a week times four weeks times three months.</p> <p>An audit was conducted and it was discovered that we had an issue with regards to a lack of an adequate bowel and bladder training program. Resident #16 has been placed on a two week trial program with our RNA team. After</p> |                      |   |

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| F 315   | Continued From page 30<br>plan also documented, undated, "He handles catheter, pulls." The interventions included:<br>** Interventions as prescribed including medication, lab work."<br>** Monitor for the need and effectiveness of medication."<br>** Assess effectiveness of interventions and adjust plan as indicated."<br>** Resident is prescribed Keflex."<br>The Care Plan also documented: "Potential for injury related to presence of indwelling catheter." Interventions included:<br>** Change collection foley catheter bag and tubing q 14 days."<br>** Change foley catheter q 4 weeks (ensure that catheter is secure at all times.)"<br>** Oxybutynin is prescribed."<br>** Resident is prescribed Keflex"<br>** Resident is to drink full glass - 8 oz- of water q 2 hours during normal waking hours."<br>** Secure catheter to thigh to prevent pulling on tubing. Keep collection bag below bladder level."<br>** Use urine collection leg bag only when resident is sitting, standing, or walking."<br>** Provide assistance to resident during transfers and ambulation."<br>** Monitor and record intake/output. Report any negative fluid balance trends to the physician."<br>** Monitor VS every shift. Report any temperature elevations to physician."<br>** Observe and document urine appearance at least daily. Report any abnormalities to physician."<br>** Change catheter per facility protocol or physician order."<br><br>The care plan failed to address catheter care, including when and how it was to be completed. | F 315  | which time as the two week trial has been completed fully, it appears they will be placed on program 3 of the urinary incontinence program and program 4 to strengthen pelvic muscles.<br><br>Resident #13 has been placed on a two week trial Program with our RNA team. After which time as the two week trial has been completed fully, it appears they will be placed on Program 1 of the Urinary Incontinence Program.<br><br>Resident #14 has been placed on a two week trial Program with our TNA team. After which time as the two week trial has been completed fully, it appears they will be placed on Program 2 of the Urinary Incontinence Programs and Program 4 to strengthen pelvic muscles.<br><br>New Residents will be assessed using the Urinary and Bowel continence Assessment to. This will guide the Intervention tool in determining the appropriate nursing interventions required. After these two items have been completed the new resident will be placed on an RNA program if they are found to have incontinence issues. |                      |   |

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| F 315   | <p>Continued From page 31</p> <p>Care instructions from a 10/7/14 appointment with a urologist documented, "Please have the foley catheter changed on 10/17/14 with a 16 french foley catheter. Change every 4 weeks based on this schedule with the next foley change. Ensure the catheter is secured at all times, not pulling on the tubing. I have sent an Rx {prescription} for Keflex 250 mg nightly for uti {urinary tract infection} prophylaxis. I discussed timed drinking. He should drink a full glass - 8 oz- of water every 2 hours during normal waking hours to help flush the urine." The physician sent catheter care instructions, but these were not added to the care plan.</p> <p>The resident was seen on 12/19/14 by an ENT {Ear, Nose, and Throat} physician for the resident's oral cancer. A physician's order, dated 12/19/14, discontinued the Keflex without any order to restart it after the antibiotic he prescribed was completed.</p> <p>On 1/6/15 at 1:00 pm, the resident had another appointment with the urologist, who ordered continuing the Keflex antibiotic. Although the resident was not taking the Keflex, this was not communicated to the urologist, and it was still listed on the "Current Medications" section of the physicians progress note. Additionally, the urologist also ordered "Apply thin ribbon/tiny amount of vaseline or bacitracin ointment around tip of catheter each day to keep catheter lubricated." This information was not care planned, nor was it added to the resident's MAR/Treatment sheet.</p> <p>On 1/13/15, the resident was admitted to the hospital with urosepsis. The physician's History and Physical documented, "...{the resident}</p> | F 315  | <p>The program will use a Urinary and Bowel Continence Assessment with appropriate Intervention Guideline tool to identify specific intervention for each category of incontinence. Nursing personnel will determine which of the four urinary programs to start the resident on after a 2 two week trial period has been completed to determine potential success rate and the appropriate program for the resident.</p> <p>This will be monitored by the DNS or Designee weekly times 4 weeks times 3 months.</p> |                      |

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| F 315   | <p>Continued From page 32</p> <p>reportedly had a fever last night...When they tried to assess him this morning, he was unresponsive except to a deep sternal rub... Patient was unresponsive in the emergency room department and found to be uroseptic... Patient has a long standing history of severe urinary obstruction due to benign prostatic hypertrophy...He has had an indwelling Foley catheter for quire sometime. He was actually just seen by Dr.{name}, the urologist, who noted in November {2014} he had a urine culture that was growing Proteus species and he is known to have some bladder stones and so she recommended consideration for a prophylactic antibiotic q.h.s. {at bedtime}, but this was apparently not communicated to the Bell Mountain staff and has not been receiving this..."</p> <p>The resident was transferred back to the facility on 1/19/15. The Discharge Summary documented, "He does have Proteus Mirabilis in his urine. He does have evidence of urinary stones, which may contribute to his ongoing recurrent infections."</p> <p>The "Blaine Manor Use and Care of Indwelling Catheters" policy and procedure, dated April 2001 and Revised June 2009, failed to provide a process for changing a catheter, maintaining a catheter, providing catheter care, and using a leg bag.</p> <p>The resident was observed each day of the survey with a catheter. The catheter was covered with clothing and the resident was not observed pulling on the catheter. The staff ambulated the resident twice a day and connected the catheter to a leg bag. The resident was observed going to bed after breakfast and lunch and sleeping until the next meal time. There were no observations of staff offering fluids, although this was</p> | F 315  |   |   |

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| F 315  | <p>Continued From page 33 documented as being done.</p> <p>The ADON was interviewed on 2/12/15 at 10:30 am about bowel and bladder issues. She did not have any information as to why he became uroseptic. No further information was provided.</p> <p>The resident was harmed when the facility failed to:</p> <ul style="list-style-type: none"> <li>- ensure the prophylactic antibiotic was continually administered.</li> <li>- catheter care was completed based on approved procedures.</li> <li>- changing from the catheter bag to the leg bag was completed based on set procedures.</li> <li>- provide 8 ounces of water every two hours. The resident slept most of the mornings and afternoons.</li> </ul> <p>The Administrator, DON and Consultant were informed on 2/11/15 at 5:00 pm. No further information was provided by the facility.</p> <p>2. Resident #16 was admitted to the facility on 10/1/14 with diagnoses of after care surgery of right hip fracture and chronic airway obstruction.</p> <p>The admission MDS assessment, dated 10/8/14, documented the resident:</p> <ul style="list-style-type: none"> <li>- Was cognitively intact with a BIMS of 15.</li> <li>- Required extensive assistance with ADLs.</li> <li>- Was occasionally incontinent of Bowel and Bladder.</li> </ul> <p>Review of the care plan it was revealed there was no toileting plan developed for the resident.</p> <p>Review of the medical record there was no assessment completed for the resident's</p> | F 315  |   |   |

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

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| F 315 | <p>Continued From page 34 incontinence.</p> <p>The MDS/ADON was interviewed on 2/12/15 at 10:30 am. She indicated there was nothing completed on the resident related to assessing her incontinence and times when she was voiding.</p> <p>The Administrator, DON and Consultant were 2/12/15 at 1:30 pm and no further information was provided.</p> <p>3. Resident #13 was readmitted to the facility on 2/4/15 with multiple diagnoses including paralysis agitans.</p> <p>The resident's 8/20/14 annual MDS assessment documented the resident was frequently incontinent of bladder and did not have a toileting plan.</p> <p>The resident's 11/18/14 quarterly MDS assessment documented the resident was always incontinent of bladder and did not have a toileting plan.</p> <p>The resident's Urinary incontinence care plan, reviewed on 10/15/14, documented as an intervention, "Toilet [Resident #13] before and after each meal and PRN..."</p> <p>A bladder assessment was not found in the medical record.</p> <p>On 2/12/15 at 10:30 AM, the MDS Coordinator was asked about the bladder assessment and she said she would look for it.</p> <p>On 2/12/15 at 12:25 PM, the MDS Coordinator</p> | F 315 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/24/2015  
FORM APPROVED  
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| F 315   | Continued From page 35<br>informed the surveyor she could not find a bladder assessment in the resident's record. She also said she could not find any documentation the facility had tried a toileting plan for the resident.<br><br>4. Resident #14 was admitted to the facility on 7/18/14 with multiple diagnoses including urinary incontinence.<br><br>The resident's 1/20/15 quarterly MDS assessment, documented the resident was occasionally incontinent of bladder and did not have a toileting plan.<br><br>The resident's Urinary Incontinence care plan, dated 7/18/14, documented a problem of, "Frequent episodes of urinary incontinence..." and an intervention of, "Encourage resident to call for assistance with toileting."<br><br>A bladder assessment was not found in the resident's medical record.<br><br>On 2/12/15 at 12:20 PM, the MDS Coordinator informed the surveyor she could not find a bladder assessment in the resident's record. She also said she could not find any documentation the facility had tried a toileting plan for the resident.<br><br>On 2/12/15 at 2:15 PM, the Administrator, DON, and Regional Operations Director were informed of the issues. No further information was provided by the facility. | F 315  |   |                      |   |
| F 328<br>SS=D   | 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS   | F 328  | F328 Resident #14's Medical Record was reviewed and updated with a corrected MD order for O2 parameters.        | 3-10-15              |   |

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

PRINTED: 02/24/2015  
FORM APPROVED  
OMB NO. 0938-0391

|   |   |  |   |                      |   |
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| F 328   | <p>Continued From page 36</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services:<br/>Injections;<br/>Parenteral and enteral fluids;<br/>Colostomy, ureterostomy, or ileostomy care;<br/>Tracheostomy care;<br/>Tracheal suctioning;<br/>Respiratory care;<br/>Foot care; and<br/>Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, record review, and staff interview, it was determined the facility failed to ensure 1 of 3 (#14) residents sampled for oxygen had appropriate parameters for staff to follow when dispensing oxygen and oxygen was delivered as ordered. This had the potential to cause the resident to have respiratory problems related to incorrect administration of oxygen. Findings included:</p> <p>Resident #14 was admitted to the facility on 7/18/14 with multiple diagnoses including hypertension and congestive heart failure.</p> <p>The resident's physician orders, dated 7/18/14, documented, "O2 [oxygen] [at] 2 L[iters]/NC [nasal cannula] for S/S [signs and symptoms] of respiratory distress notify physician" and "O2 saturation weekly and PRN on all residents requiring oxygen."</p> <p>The resident's February 2015 MAR, documented, "O2 [at] 2 L/NC for S/S of respiratory distress notify physician" and "O2 saturation weekly and</p> | F 328  | <p>All other Residents Medical Record receiving O2, were reviewed, and updated if necessary to ensure that the MD orders for O2 parameters were easily identifiable in the MD Orders and the care plans.</p> <p>The DNS will review all new orders from the MD and ensure they are implemented correctly into the MAR and care plans. Quarterly Assessments will also address the accuracy of the O2 orders as will any change of conditions.</p> <p>Weekly, all new orders for O2 will be reviewed for accuracy in the Medical record will be reviewed and presented to the QA committee every month. Weekly audit of all residents with O2 will occur weekly times four weeks times three months.</p> |                      |   |

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

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|   |   |  |   |                      |   |
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| F 328   | Continued From page 37<br>PRN on all residents requiring oxygen."<br><br>The resident's Congestive Heart Failure care plan, dated 7/18/14, documented interventions of, "O2 [at] 2 L/NC for S/S of respiratory distress notify physician" and "O2 saturation weekly and PRN on all residents requiring oxygen."<br><br>The resident's Nurses Note, dated 2/9/15, documented a late entry for 2/8/15, "Oxygen sats were 91% on 2 L, increased to 3 L with better sats."<br><br>On 2/9/15 at 2:35 PM, the resident was observed in her room with oxygen delivered via NC with the wall mount unit set on 3 liters.<br>On 2/10/15 at 9:16 AM, the resident was observed in the dining room with oxygen delivered via NC with the portable oxygen tank set at 2 liters.<br>On 2/10/15 at 10:40 AM, the resident was observed in her room with oxygen delivered via NC with the wall mount unit set on 2 liters.<br><br>On 2/12/15 at 8:40 AM, the DON was interviewed regarding the oxygen issues. When asked if the order documented frequency of the oxygen use, she said it was for continuous flow but the order did not indicate that. When asked if the order documented parameters on when to titrate, by how much, and what saturation levels would justify an increase, she stated, "There is not."<br><br>On 2/12/15 at 2:15 PM, the Administrator, DON, and Regional Operations Director were informed of the issues. No further information was provided by the facility. | F 328  |   |                      |   |
| F 367   | 483.35(e) THERAPEUTIC DIET PRESCRIBED   | F 367  |   |                      |   |

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

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FORM APPROVED  
OMB NO. 0938-0391

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| F 367<br>SS=D   | Continued From page 38<br>BY PHYSICIAN<br><br>Therapeutic diets must be prescribed by the attending physician.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and dietary card/spreadsheet review, it was determined the facility failed to ensure that 1 of 8 (#8) residents received the therapeutic diet the physician ordered. There was a potential for harm if the resident aspirated food of the wrong consistency. Findings include:<br><br>Resident #8 was admitted to the facility on 9/21/14, and readmitted on 1/19/15, with diagnoses of dementia with behavior disturbance, Alzheimer's disease and Benign Prostatic Hyperplasia.<br><br>The physician on 1/29/15 wrote an order that documented, "Change Diet to pureed foods due to resident is unable to chew his food."<br><br>On 2/10/15, the dietitian documented on a Nutrition Assessment that the resident was to receive a "regular diet, pureed, NEM (nutrition enhanced meals); and increased calorie desserts." The assessment further documented the resident had impaired ability to chew and swallow, but was able to eat a pureed diet.<br><br>On 2/10/15 at 6:20 pm, the resident was observed with a meal that had the consistency of a mechanical soft diet. The resident's diet card was reviewed and it showed a mechanical soft, cut up meat, NEM diet. The facility's cook | F 367  | F367 Resident #8's Medical Record audited to ensure that the correct MD order and RD diet were documented and care planned.<br><br>All Residents charts were audited to ensure that the Therapeutic diets were ordered as need by the MD, noted, care planned and the Kitchen staff had Identifiers that matched the Therapeutic diet.<br><br>During meals Dining room Managers will check the meal cards for each Resident for Accuracy. An in-service was conducted on 2-24-15 and 2-25-14. Any inconsistencies will be reported to the Kitchen staff immediately and to the nursing staff and the Administrator and Dietary manager the next day at morning meeting.<br><br>All new dietary orders will be reviewed by the DNS with the Dietary manager and the Registered Dietician to ensure compliance and accuracy for all Residents receiving Therapeutic diets. The Registered Dietician and/or Dietary Manager will conduct an audit of the | 3-23-15   |

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

PRINTED: 02/24/2015  
FORM APPROVED  
OMB NO. 0938-0391

|   |   |  |   |                      |   |
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| F 367   | Continued From page 39<br>spreadsheet documented the resident was to receive a pureed regular diet with NEM's and high calorie deserts.<br><br>On 2/10/15 at 6:30 pm, when interviewed about the consistency of the resident's meal, the dietitian acknowledged the resident had received a mechanical soft meal, which was what the resident had requested.<br><br>On 2/11/15 at 5:00 pm, the consistency of the resident's meal with the Administrator and DON present. The dietitian had researched the issue and found the 1/29/15 order changing the resident to a pureed diet.  | F 367  | cook's meals for five consecutive day starting 3/1/15. Weekly audits times four weeks times three months by the RD and DM.  |                      |   |
| F 431<br>SS=E   | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to | F 431  | F431 – Residents #'s 3, 8, 13, 14, 15, 16, 17, & 19 Medical Records were audited to verify that they had no adverse drug reactions to any medications.<br><br>All other Residents charts were reviewed to ensure that there were not any adverse drug reactions due to medications. The pharmacy was called on 3-5-15 and they will replace The E-Kit with a Pyxis medication station in the following weeks to accurately monitor the use of and outdates of the emergency Medication and will monitor for outdates on their monthly visits. | 3-23-15              |   |

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

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| F 431   | <p>Continued From page 40<br/>have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, it was determined the facility failed to ensure outdated medications were not available for resident use. This had the potential to affect all residents in the facility, including 8 of 8 (#s 3, 8, 13, 14, 15, 16, 17, &amp; 19) sampled residents. There was a potential for harm if outdated medications were used due to a potential decrease in potency. Findings include:</p> <p>On 2/11/15 at 11:15 pm, the 20 outdated medications were found in the medication room. These included:</p> <ul style="list-style-type: none"> <li>- 2 vials of Diphenhydramine HCL 50 mg/ml injectable, 1 mil vile, expired November 2014,</li> <li>- 3 packages of Klonopin 0.5 mg tablets, expired December 2014,</li> <li>- 2 packages Omnicef Cefdinir 300 mg capsules, expired January 2015,</li> <li>- 4 packages of Restoril 15 mg capsules, expired May 2014,</li> <li>- 4 packages of Zyprexa 10 mg tablets, expired January 2015,</li> <li>- 5 packages of Detrol LA 2 mg tablets, expired</li> </ul> | F 431  | <p>An In-service was held on 2-17-15 all nursing personnel to explain the new procedures for outdated Medications tracking and disposal. All outdated medications will be collected upon expiration by the DNS and/or designee and stored in a double locked area before disposal if they cannot be disposed of that day, according to the new policy and procedures for medication disposals developed 1-28-15.</p> <p>Regular rounding by the DNS and/or designee will be conducted weekly times four weeks times three months and documented per brand new policy and procedures. When medication is destroyed documentation will be kept in a "Medication Disposal Log" and reviewed by the consulting Pharmacist monthly.</p> |   |

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

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| F 431   | Continued From page 41<br>December 2014.  | F 431  |  |                      |   |
| F 441<br>SS=F   | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted | F 441  | F441 Resident's #3, 8, 13, 14, 15, 16, 17, 18, & 19 Medical Records were reviewed and audited to determine if any of these Resident's had been adversely affected the previous facilities Infection control policy and procedures from 2010. All other Residents charts were audited to ensure that they had not been negatively affected.<br><br>All new admissions will be encouraged to accept influenza or pneumonia vaccinations if appropriate.<br><br>The DNS and Administrator updated the policy for new facility on 3-6-15 that was wrote on 1-29-15 and it has been developed and implemented by the Administrator, DNS and Medical Director. DNS will use appropriate forms and calculate all trends from collected data on all residents. | 3/23/15              |   |

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

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| F 441   | <p>Continued From page 42 professional practice.</p> <p>(c) Linens<br/>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on interview and policy review, it was determined the facility failed to maintain an infection control program by conducting surveillance, analyzing data and trending infections within the facility. This had the potential to affect all residents in the facility, including 9 of 9 (#s 3, 8, 13, 14, 15, 16, 17, 18, &amp; 19) sampled residents. This failure put residents at risk for the spread of infection throughout the facility. Findings include:</p> <p>On 2/11/15 the Infection Control policy was reviewed. The facility medical staff had not reviewed the policies since June of 2010. The policy lacked current information about diseases and infections including flu, pneumonia, and other drug resistant bacteria.</p> <p>The surveillance process outlined two types of surveillance processes the facility was to use; however, there was no documented surveillance completed for November 2014 and December 2014. The DON collected data on residents for January 2015 but failed to analyze and trend the information. The nosocomial rate was not calculated and a report was not generated for review by the infection control committee.</p> | F 441  | <p>QA committee will meet monthly and all infection control reports will be completed prior to the QA meeting from the DNS and then presented to the QA team for review. All infections will be audited weekly times four weeks times three months by DNS or designee and all monthly trends will be audited on the last working day of the month times three months by DNS or designee.</p> |   |

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PRINTED: 02/24/2015  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                        |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>135069 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br>C<br>02/12/2015 |
|---|--|--|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>BELL MOUNTAIN VILLAGE & CARE CENTER |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>706 SOUTH MAIN STREET<br>HAILEY, ID 83333  |                      |   |
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| F 441   | Continued From page 43<br>The DON was interviewed on 2/11/15 at 2:55 pm. and acknowledged the process had not been followed using the recommended forms from the policy. No further information was provided by the facility.  | F 441  |   |                      |   |
| F 456<br>SS=D   | 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION<br><br>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, and resident and staff interview, it was determined the facility failed to maintain a resident's wheelchair arm and two residents' wheelchair brakes in a safe operating condition. This was true for 2 of 9 (#s 13 & 16) sampled residents and one random resident (#22). This had the potential for skin injury for a resident and accidents for two other residents. Findings included:<br><br>On 2/9/15 at 2:40 PM and 2/10/15 at 10:45 AM, Resident #13 was observed in his wheelchair. The right arm of the wheelchair was missing and in its place was a thin pad which covered the back half of the round metal bar with the front half showing an exposed round metal bar. The resident's arm was resting on both the pad and the exposed metal bar. The tip of the metal bar was covered with a round plastic insert.<br><br>On 2/10/15 at approximately 2:45 PM, Resident #16's and #22's wheelchair brakes were observed. Resident #16's left brake was broken | F 456  | F456 – Facility prior practice did not have a maintenance repair log which lead to a systemic failure and this has been corrected to having a new maintenance repair log or use of the TELS system Resident's #13, #16 and #20 wheelchairs were repaired on 2-10-15.<br><br>Staff will report any items in need of servicing by the Maintenance department to Administrator or Designee. All Maintenance items will be entered into the TELS system or Maintenance repair log by any staff member.<br><br>Daily the Maintenance supervisor will conduct rounding of the Resident's mobility equipment to ensure that they are in safe working condition. In addition, the Maintenance supervisor will check the TELS system and or Maintenance repair log to repair any required necessary items to insure all essential mechanical, electrical and | 3-10-15              |   |

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| F 456   | Continued From page 44<br>and Resident #22's right brake was loose.<br><br>On 2/10/15 at 3:20 PM, the facility's owner was informed of the wheelchair issues. He said the wheelchairs would be fixed within the hour.<br><br>On 2/10/15 at 3:50 PM and 5:50 PM, the three resident's wheelchair issues were observed to be fixed.<br><br>On 2/10/15 at 7:35 PM, the Administrator, DON, and Regional Operations Director were informed of the issues.   | F 456  | patient care are in safe operating conditions.<br><br>The Safety committee will review the TELS system and/or Maintenance log for effectiveness and also any outstanding needs, if any, of needed repairs to all Resident equipment for compliance.   |                      |   |
| F 494<br>SS=E   | 483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY<br><br>A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b).<br><br>A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section.<br><br>Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter. | F 494  | F494 – The previous Provider did not hire uncertified Nursing Assistants (NA). All nurse Aides were presumed to be Certified Nursing Assistants. New hires can now be NA's working towards the certification. Staff G has been released from duty pending proof of acquiring certification.<br><br>There were no Residents harmed by this oversight concerning the cares provided by staff G.<br><br>As of 2-13-15 the Human Resources department has developed a log system for tracking and monitoring any staff hired as NA's to ensure they are in compliance with regulatory guidelines and do not work past 120 days of hire. | 2-13-15              |   |

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| F 494   | <p>Continued From page 45</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observations, staff interviews, and personnel record review, it was determined the facility failed to ensure 1 of 3 sampled Nurse Aides (Staff #G) had completed a CNA training and competency evaluation program within four months of his hire date as required by law. Findings include:<br/>On 2/10/15 at 6:12 PM, Staff #G was observed in the dining room assisting residents with their meals.<br/><br/>On 2/10/15 at 6:18 PM, Staff #G was interviewed and he said he had not taken the CNA certification test yet.<br/><br/>On 2/12/15 at 9:15 AM, the Business Office Manager was interviewed. She stated Staff #G was hired on 9/14/14 and had taken CNA classes, but failed the written part of the test and had not retaken it yet. Note: The Nurse Aide had worked at the facility for more than four months at the time of the observation.<br/><br/>On 2/12/15 at 2:15 PM, the Administrator, DON, and Regional Operations Director were informed of the issues. No further information was provided by the facility.</p> | F 494  | The Human Resource department will review with the Administrator and DNS on all NA compliance concerns. NA's that are found to be near the 120 day period will be released if they cannot provide proof of written certification of completion for a Certified Nursing Assistant. |   |

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| C 000 | <p><b>16.03.02 INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the annual state licensure and complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were:<br/>Arnold Rosling RN, BSN QMRP, Team Coordinator<br/>Brad Perry LSW</p> <p>The survey team entered the facility on February 9, 2015 and exited on February 12, 2015.</p>  | C 000 |           |         |
| C 099 | <p><b>02.009 CRIMINAL HISTORY AND BACKGROUND CHECK REQUIRE</b></p> <p>01. Criminal History and Background Check. A skilled nursing and intermediate care facility must complete a criminal history and background check on employees and contractors hired or contracted with after October 1, 2007, who have direct patient access to residents in the skilled nursing and intermediate care facility. A Department check conducted under IDAPA 16.05.06, "Criminal History and Background Checks," satisfies this requirement. Other criminal history and background checks may be accepted provided they meet the criteria in Subsection 009.02 of this rule and the entity conducting the check issues written findings. The entity must provide a copy of these written findings to both the facility and the employee.<br/>(3-26-08)</p> <p>02. Scope of a Criminal History and Background Check. The criminal history and background check must, at a minimum, be a fingerprint-based criminal history and background check that includes a search of the following record sources:<br/>(3-26-08)</p> <p>a. Federal Bureau of Investigation (FBI);</p> | C 099 | See F 226 | 3-10-15 |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Nowakowski*

TITLE

*NHA*

(X6) DATE

*3/11/15*

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| C 099              | <p>Continued From page 1</p> <p>(3-26-08)</p> <p>b. Idaho State Police Bureau of Criminal Identification; (3-26-08)</p> <p>c. Sexual Offender Registry; (3-26-08)</p> <p>d. Office of Inspector General List of Excluded Individuals and Entities; and (3-26-08)</p> <p>e. Nurse Aide Registry. (3-26-08)</p> <p>03. Availability to Work. Any direct patient access individual hired or contracted with on or after October 1, 2007, must self-disclose all arrests and convictions before having access to residents. The individual is allowed to only work under supervision until the criminal history and background check is completed. If a disqualifying crime as described in IDAPA 16.05.06, "Criminal History and Background Checks," is disclosed, the individual cannot have access to any resident. (3-26-08)</p> <p>04. Submission of Fingerprints. The individual's fingerprints must be submitted to the entity conducting the criminal history and background check within twenty-one (21) days of his date of hire. (3-26-08)</p> <p>05. New Criminal History and Background Check. An individual must have a criminal history and background check when: (3-26-08)</p> <p>a. Accepting employment with a new employer; and (3-26-08)</p> <p>b. His last criminal history and background check was completed more than three (3) years prior to his date of hire. (3-26-08)</p> <p>06. Use of Criminal History Check Within Three Years of Completion. Any employer may use a previous criminal history and background check obtained under these rules if: (3-26-08)</p> | C 099         |   |                    |

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| C 099 | <p>Continued From page 2</p> <p>a. The individual has received a criminal history and background check within three (3) years of his date of hire;<br/>(3-26-08)</p> <p>b. The employer has documentation of the criminal history and background check findings;<br/>(3-26-08)</p> <p>c. The employer completes a state-only background check of the individual through the Idaho State Police Bureau of Criminal Identification, and<br/>(3-26-08)</p> <p>d. No disqualifying crimes are found.<br/>(3-26-08)</p> <p>07. Employer Discretion. The new employer, at its discretion, may require an individual to complete a criminal history and background check at any time, even if the individual has received a criminal history and background check within the three (3) years of his date of hire. (3-26-08)</p> <p>This Rule is not met as evidenced by:<br/>Refer to F226 regarding Nurse Aide Registry check issues.</p> | C 099 |           |         |
| C 118 | <p>02.100,03,c,ii Available Services and Charges</p> <p>ii. Is fully informed, prior to or at the time of admission and during stay, of services available in the facility, and of related charges including any charges for services not covered under Titles XVIII or XIX of the Social Security Act, or not covered by the facility's basic per diem rate;<br/>This Rule is not met as evidenced by:<br/>Refer to F 156 as it relates to informed consent.</p>   | C 118 | See F 156 | 3-10-15 |

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| C 121              | 02.100,03,c,v Encouraged/Assisted to Exercise Rights<br><br>v. Is encouraged and assisted, throughout his period of stay, to exercise his rights as a patient/resident and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;<br>This Rule is not met as evidenced by:<br>Refer to F151 regarding voting issues. | C 121         | See F 151   | 3-10-15            |
| C 125              | 02.100,03,c,ix Treated with Respect/Dignity<br><br>ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;<br>This Rule is not met as evidenced by:<br>Refer to F241 regarding standing while assisting residents during meals.   | C 125         | See F 241   | 3-16-15            |
| C 293              | 02.107,04,b Therapeutic Diets per Physician Orders<br><br>b. Therapeutic diets shall be planned in accordance with the physician's order. To the extent that it is medically possible, it shall be planned from the regular menu and shall meet the patient's/resident's daily need for nutrients.<br>This Rule is not met as evidenced by:<br>Refer to F 367 as it relates to therapeutic diets.  | C 293         | See F 367   | 3-23-15            |

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| C 361              | 02.108,07 Housekeeping Services and Equipment<br><br>07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner.<br>This Rule is not met as evidenced by:<br>Refer to F253 regarding housekeeping issues.  | C 361         | See F 253   | 2-27-15            |
| C 665              | 02.150,02,b Develop/Implement Policies/Procedures<br><br>b. Be responsible for development and implementation of infection control policies and procedures including the designation of a facility employee to monitor practices within the facility.<br>This Rule is not met as evidenced by:<br>Please refer to F441 as it relates to infection control.   | C 665         | See F 441   | 3-6-15             |
| C 667              | 02.150,02,d Annual Review of Policies/Procedures<br><br>d. Review policies and procedures as needed but no less often than annually.<br>This Rule is not met as evidenced by:<br>Based on review of the infection control policies and procedures, it was determined the facility failed to review policies annually. Findings include:<br><br>The Infection control policies were last reviewed by the Administrator and DON on 6/16/10 and the | C 667         | See F 226   | 3-10-15            |

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| C 667              | Continued From page 5<br>physician reviewed them on 6/22/10.   | C 667         |   |                    |
| C 669              | 02.150,03 Resident Protection<br><br>03. Patient/Resident Protection. There is evidence of infection control, prevention and surveillance in the outcome of care for all patients/residents as demonstrated by:<br><br>This Rule is not met as evidenced by:<br>Refer to F 441 as it relates to infection control surveillance.  | C 669         | See F 441   | 3-23-15            |
| C 674              | 02.151,01 Activities Program<br><br>151. ACTIVITIES PROGRAM.<br><br>01. Organized Program. There shall be an organized and supervised activity program appropriate to the needs and interests of each patient/resident. The program shall be designed to include a variety of processes and services which are designed to stimulate patients/residents to greater self-sufficiency, resumption of normal activities and maintenance of an optimal level of psychosocial functioning. It shall include recreation, therapeutic, leisure and religious activities.<br>This Rule is not met as evidenced by:<br>Refer to F248 regarding lack of variety and lack of communication of activities program. | C 674         | See F 248   | 3-10-15            |

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| C 782              | Continued From page 6   | C 782         |   |                    |
| C 782              | 02.200,03,a,iv Reviewed and Revised<br><br>iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished;<br>This Rule is not met as evidenced by:<br>Refer to F280 regarding care plan revision issues.   | C 782         | See F 280   | 3-10-15            |
| C 788              | 02.200,03,b,iv Medications, Diet, Treatments as Ordered<br><br>iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner;<br>This Rule is not met as evidenced by:<br>Refer to F328 regarding oxygen order issues.  | C 788         | See F 328   | 3-10-15            |
| C 789              | 02.200,03,b,v Prevention of Decubitus<br><br>v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation;<br>This Rule is not met as evidenced by:<br>Refer to F 314 as it relates to pressure sores. | C 789         | See F 314   | 3-23-15            |
| C 795              | 02.200,03,b,xi Bowel/Bladder Evacuation/Retraining<br><br>xi. Bowel and bladder evacuation and bowel and bladder retraining programs as indicated;  | C 795         | See F 315   | 3-23-15            |

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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) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
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|       |  |       |           |         |
|-------|--|-------|-----------|---------|
| C 795 | Continued From page 7<br><br>This Rule is not met as evidenced by:<br>Please refer to F315 as it refers to incontinence retraining programs and catheter care.   | C 795 |           |         |
| C 821 | 02.201,01,b Removal of Expired Meds<br><br>b. Reviewing all medications in the facility for expiration dates and shall be responsible for the removal of discontinued or expired drugs from use as indicated at least every ninety (90) days.<br><br>This Rule is not met as evidenced by:<br>Refer to F 431 as it relates to expired medications. | C 821 | See F 431 | 3-23-15 |



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

FILE COPY

February 26, 2015

Tobi L. Lucero, Administrator  
Bell Mountain Village & Care Center  
706 South Main Street  
Hailey, ID 83333-8400

Provider #: 135069

Dear Ms. Lucero:

On **February 12, 2015**, an unannounced on-site complaint survey was conducted at Bell Mountain Village & Care Center. This complaint was investigated in conjunction with the annual Recertification & State Licensure survey. The survey team entered the facility on February 9, 2015, and exited on February 12, 2015.

The allegations were already brought to the attention of the survey team shortly after a complaint investigation survey with an exit date of November 19, 2014. Some of the allegations in this complaint are similar to those investigated, substantiated and cited.

The following documents were reviewed:

- The medical records of ten residents, including the identified resident;
- The facility's Grievance/ Complaint Notice file, including a grievance filed on behalf of the resident, and
- The facility's incident and accident reports.

Observations of residents' care was conducted throughout the survey, the kitchen and meal time observations were conducted and a variety of staff including the administrator, the current Director of Nursing (DoN), licensed nurses and Certified Nurse Aides (CNAs) were interviewed.

The complaint allegations, findings and conclusions are as follows:

### **Complaint #6763**

#### **ALLEGATION #1:**

The complainant reported that a nurse found a wound on resident's "buttocks" that was the "size of a nickel, deep, and very infected." Staff reported it was a "moisture spot" and not a pressure ulcer. Staff said the resident would be taken to a wound specialist. According to the complainant, the resident who was unable to stand independently spent the majority of his time in his wheelchair or in bed rather than in a recliner or another chair.

#### **FINDINGS #1:**

The resident's record was reviewed and on November 12, 2014, the wound and skin record documented the resident had a three centimeter by three centimeter sore on the right buttock, coccyx area. The resident was seen in the wound clinic twice. The last visit to the clinic assessed the pressure ulcer sore as a stage four pressure sore. The medical record documented the resident was "first down (in bed) and last" up out of bed. The resident did spend most of the time in bed. There was enough documentation on the pressure ulcer in the resident's medical record to substantiate that the allegation occurred and the resident was harmed. The facility was cited at F314 for failure to prevent the development of pressure ulcers.

#### **CONCLUSIONS:**

Substantiated. Federal and State deficiencies related to the allegation are cited.

#### **ALLEGATION #2:**

The complainant said the resident's family was not notified timely of the resident's pressure ulcer.

#### **FINDINGS #2:**

The medical record and incident reports were reviewed. There was no documentation in the medical record indicating when the family was notified of the pressure ulcer. An incident report, dated November 13, 2014, documented the sore was discovered at 2:00 a.m. The incident report documented the family was notified at 12:00 p.m. A second incident report documented afternoon. Based on the two reports the family was not notified in a timely manner.

The deficient practice was validated and cited at the November 2014 survey. The citation was F157. Please refer to that survey for more information.

#### **CONCLUSIONS:**

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #3:

The complainant said the food was "terrible." No further specifics were given.

FINDINGS #3:

A complaint about the food was investigated during the November 2014 complaint survey; however, it could not be validated at the time of that survey. This complaint was investigated during the annual recertification survey completed on February 12, 2015. Two meal observations and a kitchen inspection were conducted. A Registered Dietitian oversaw the preparation and serving of the food. Random residents were asked during meals about the food. A group meeting was held with residents on February 10, 2015, with questions posed to residents about the food. There were no complaints voiced and most all residents ate the food offered to them. There were even comments made about the variety of food improving.

This allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant said the resident was often found unshaved, unkempt and with poor hygiene (shower, teeth, etc.)

FINDINGS #4:

When the survey team entered the facility during the recertification survey, a tour was completed. One of the required observations on the tour was looking at residents' grooming. After the tour was completed, a sample of six residents was picked. These residents are specifically observed during the survey for grooming and documentation of the cares they received was reviewed. Residents were interviewed as well. No concerns related to grooming, hygiene or bathing were noted.

This allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant said the administrator of record was "never on site," only the administrator in

training (AIT), who had not received adequate training, was at the facility. When brought to the administrator's attention, issues were not appropriately addressed. Residents and/or their families feared retribution.

FINDINGS #5:

On November 19, 2014, a person from the Idaho Board of Examiners for Nursing Home Administrators, Bureau of Occupational Licenses was contacted. She stated, once the board has approved the application for Administrator in Training (AIT), the preceptor must meet with the AIT a minimum of 32 hours a month or 8 hours a week. The AIT can manage the building with minimum over-site from the preceptor. The facility was meeting the minimum requirements at the time the complaint came into the office.

In January 2015, the owner of the facility hired a full time administrator. The administrator was licensed and qualified to manage the building. In addition, a new DoN and Social Worker were hired. During the February 12, 2015, survey, it was noted that the new staff were easy to talk with and appeared to listen to issues and input from staff, residents and their families. There was no indication an employee's job or a resident's occupancy in the facility was in jeopardy if a complaint was voiced or filed.

The allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant said a female resident fell out of a wheelchair while attempting to reach a television remote control. Staff was preoccupied with newly admitted resident with mental illness and violent behaviors. The female resident was transported to hospital and did not return until next day.

FINDINGS #6:

This incident was investigated during the November 14, 2014, survey. The findings are as follows:

Based on review of the November 1, 2014, Incident and Accident report; the November 1, 2014, Occurrence Report and the Investigative Report submitted to the Bureau of Facility Standards on November 7, 2014, the following information was obtained:

The Investigative Report documented that on November 1, 2014, at about 7:30 p.m. a resident

was taken into her room after dinner. The CNA left the room and closed the residents' door. The report documented the "door was closed to help prevent possible intrusion by resident, (resident's name), during a particularly agitated state." The Occurrence Report documented the other resident had already physically attacked a staff member.

The Investigative Report documented the facility had twenty-two residents. There were two CNAs and one LPN on this shift. The DoN was present and providing one-to-one supervision for the resident exhibiting behaviors. The schedule for November 1, 2014, revealed that one of the CNAs was only scheduled to work from 5:00 p.m. to 9:00 p.m.

The Incident and Accident documented on November 1, 2014, at 8:30 p.m., the resident "was laying on the floor in front of her wheelchair with her left leg caught in an awkward position." The resident was transported to the hospital at 9:00 p.m.

The hospital's emergency report documented the resident did not have a fracture but did have a skin tear that was treated. The resident returned to the facility at 11:00 p.m. with a dressing over the leg's injury.

The DoN and Assistant Administrator were interviewed on November 14, 2014, at 11:45 a.m. They indicated the resident was not unattended for more than a couple minutes; however, the facility's documentation reveals the resident was unattended for up to one hour. The staff were busy with an aggressive resident and the documentation was vague with showing what the facility was doing from 7:30 p.m. to 8:30 p.m. when the resident, who was left unattended with her room door closed, was found on the floor in her room.

The allegation was substantiated and the facility was cited at F323 during the November 2014 survey.

#### CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

#### ALLEGATION #7:

The complainant said a violent resident who was discharged had been under one to one supervision; however, the staff member in that one to one relationship was a "slight" woman who worked as a receptionist and activities coordinator and not nearly strong enough to adequately monitor and/or supervise the resident who displayed violent behavior.

#### FINDINGS #7:

Documentation of resident one to one supervision was reviewed during the November 2014 complaint investigation. Several staff provided one to one supervision time with the resident

identified in this allegation in an effort to ensure his safety and the safety of other residents. Results of the November 2014 complaint investigation included the following:

On October 29, 2014, at 5:26 p.m. the Licensed Nurse (LN) documented, "Resident became violent with staff today at approximately 1445 (2:45 p.m.) He grabbed a CNA by the arm and twisted it up and forcing her to walk down the hall. Another CNA and RN intervened to get CNA out of residents grip... He then began grabbing silverware off the tables... Resident was able to grab a butter knife and took off out of the dining area. RN tried to get resident to give her the knife but resident would not release the knife. RN was able to slide knife out of resident's hand. Resident then walked down the hall, saw another CNA, held his hand up to her throat then dropped his hands. Resident was calm after that."

On November 10, 2014, at 6:55 a.m. the LN documented, "The resident was one on one from 7pm to 11pm, one on one from 3am - 7am, R/T (related to) fall risk, grabing (sic) people, going in other peoples (sic) rooms, fall risk to other resident."

On November 10, 2014, at 12:36 p.m. the LN documented, "Resident has been one on one care this shift with a staff member at his side at all times... Is incontinent of bowel and bladder due to confusion and refusal to sit on the toilet due to cognitive issues..."

The resident was observed by surveyors from November 12, 2014, through November 14, 2014. The resident had a one-to-one during the day and was observed with the night RN during the early morning observations. The resident did not exhibit any aggressive behaviors, wandered but was easily redirected. The resident's wife was seen interacting with the resident. On November 14, 2014, there was a resident-to-resident altercation with the resident and another resident.

The DoN and Assistant Administrator were interviewed on November 14, 2014, at 11:45 a.m. about the resident's behaviors, documentation, behavior plan and policies for residents with maladaptive behaviors. The facility did not have policies for addressing behaviors. The facility's staff interacted with the resident well, but there was no treatment plan other than the treatment plan he came with, which did not provide sufficient direction for staff. No further information was provided.

The facility was not adequately staffed or trained to provide the level of care the resident needed. The allegation was substantiated and the facility was cited at F323 during the November 2014 survey.

#### CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #8:

The complainant alleged the staff are working double shifts and often appear "sleepy" or "nod off" when on duty.

FINDINGS # 8:

A similar allegation was investigated during the November 2014 complaint survey. The allegation was not substantiated at the time. During the February 12, 2015, survey, staffing patterns were again reviewed. Staffing exceeded the minimum requirements. The facility had hired new employees to cover for the ones who were terminated. There were twenty-one residents in the facility. On day shift, there were two CNA's to provide care as well as a bath aide and a restorative CNA. The afternoon and night shifts each had two CNAs as well as licensed staff to provide care. None of the staff behaviors alleged by the complainant were observed during the survey.

The allegation was not substantiated.

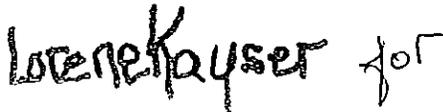
CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option #2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser" followed by a stylized flourish.

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

DS/dmj



IDAHO DEPARTMENT OF  
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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
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FILE COPY

February 26, 2015

Tobi L. Lucero, Administrator  
Bell Mountain Village & Care Center  
706 South Main Street  
Hailey, ID 83333-8400

Provider #: 135069

Dear Ms. Lucero:

On **February 12, 2015**, we conducted an on-site follow-up revisit to the complaint investigation conducted on November 19, 2014, 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 **December 23, 2014**. However, based on our on-site follow-up revisit conducted **February 12, 2015**, we found that your facility is not in substantial compliance with the following participation requirements:

**F281 -- 42 CFR §483.20(k)(3)(i)**

**F323 -- 42 CFR §483.25(h)**

**F329 -- 42 CFR §483.25(l)**

In addition, a Recertification, Complaint Investigation and State Licensure survey was conducted in conjunction with the on-site follow-up. Please see separate cover letter and Statement of Deficiencies and Plan of Correction, Form CMS-2567 related to the facility not being in substantial compliance with federal regulatory requirements as a result of that survey.

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**

Tobi L. Lucero, Administrator  
February 26, 2015  
Page 2 of 4

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 **March 11, 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 **December 4, 2014**, following the **Complaint Investigation** survey of

Tobi L. Lucero, Administrator  
February 26, 2015  
Page 3 of 4

**November 19, 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 **May 19, 2015**, if substantial compliance is not achieved by that time.

Please refer to the letter from CMS dated **December 5, 2014**, and any further communications from them that outlines recommended and/or imposed remedies related to the Complaint Investigation survey of November 19, 2014, and/or the Recertification, Complaint Investigation and State Licensure survey of February 12, 2015.

**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.**

STATE ACTIONS effective with the date of this letter (**February 23, 2015**): None

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

Tobi L. Lucero, Administrator

February 26, 2015

Page 4 of 4

This request must be received by **March 11, 2015**. If your request for informal dispute resolution is received after **March 11, 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., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option #2.

Sincerely,

Lorene Kayser / for

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

DJS/dmj  
Enclosures

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

PRINTED: 02/24/2015  
FORM APPROVED  
OMB NO. 0938-0391

|   |   |  |   |   |
|---|---|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                        |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>135069 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br>R-C<br>02/12/2015 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BELL MOUNTAIN VILLAGE & CARE CENTER |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>706 SOUTH MAIN STREET<br>HAILEY, ID 83333  |   |
| (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                                |
| {F 000}   | INITIAL COMMENTS<br><br>The following deficiencies were cited during the follow-up to a complaint investigation survey of your facility.<br><br>The surveyors conducting the survey were:<br>Arnold Rosling RN, BSN QMRP, Team Coordinator<br>Brad Perry LSW<br><br>The survey team entered the facility on February 9, 2015 and exited on February 12, 2015.   | {F 000}  | <p style="text-align: center;">RECEIVED<br/>MAR 27 2015<br/>FACILITY STANDARDS</p> <p>F281 – The previous provider Blaine Manor’s practice was that that the RHIT would enter all orders without nursing triple checking the orders and that has been changed to the RHIT entering orders and then the Nurses are checking those orders that was entered and the DNS is reviewing all new orders within 72 hours to insure that proper transcription of orders, times, routes, interactions are reviewed. Resident’s #14 records were reviewed and an order was put in the MAR for Humalog to be given at 17:30, RN #2 gave medication at 17:15 and education was provided about Eli Lilly recommendations for use of Humalog Insulin. Resident #18 medical record were reviewed and new physician orders were obtained to insure Jevity was stopped 1 hour prior to administration of Sinemet and Jevity was not resumed until 2 hours after Sinemet was administered.</p> | 2-17-15   |
| {F 281} SS=D  | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents received diabetic care and medications that met clinical standards of practice. This was true for 2 of 9 (#s 14 & 18) sampled residents. There was a potential for harm when diabetic care and medications were not provided according to established standards of practice. Findings include:<br><br>1. Resident #14 was admitted to the facility 7/18/14 with diagnoses of diabetes mellitus without complications, depressive disorder, and long term use of insulin.<br><br>The resident's February 2015 recapitulation orders documented the resident was to receive, | {F 281}  |   |   |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Now Fucaro* TITLE: *NHA* (X6) DATE: *3/11/15*

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

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| {F 281}   | <p>Continued From page 1</p> <p>"Humalog Insulin 5 units subcutaneously {sq} before dinner," and "... 5 units of Humalog if Blood Glucose is greater then 400."</p> <p>The information at <a href="http://www.humalog.com">http://www.humalog.com</a>, provided by the drug manufacturer Eli Lilly and company LLC, dated 2014, documented, "How should I use Humalog?, *Humalog is a rapid-acting insulin. Take Humalog within fifteen minutes before eating or right after eating a meal."</p> <p>On 2/10/15 at 5:15 p.m., Resident #14 had a blood glucose of 429. The resident received 10 units of Humalog insulin sq. The resident was observed by two surveyors until 6:15 p.m. The resident did not receive any nutrition for one hour after receiving the insulin. The resident did not have any noticeable reactions to the medication.</p> <p>On 2/11/15 at 9:00 a.m., RN #2 was interviewed and indicated that the time of administration would be changed to 6 p.m. The RN was not aware of the long delay from administration until the resident ate a meal. No further information was provided.</p> <p>2. Resident #18 was admitted to the facility 9/27/07 with diagnoses of late effect acute polio, paranoid state, depressive disorder and gastrostomy. The resident also had some spasticity of the extremities.</p> <p>The most recent quarterly assessment, dated 12/16/14, documented the resident:</p> <ul style="list-style-type: none"> <li>- had short and long term memory impairment.</li> <li>- had severely impaired decision making skills.</li> <li>- was total assist with all cares.</li> <li>- had decreased range of motion to upper and</li> </ul> | {F 281}  | <p>All nursing staff were in serviced by the DNS on 2/17/2015 as to policy and procedure for administering medications to all Residents receiving Diabetic medications and other medications administered to Residents receiving Nasogastric/Gastric tube feedings. Specifically, Sinemet. At this time we have no other residents on Insulin.</p> <p>All new admits will have complete medication review by DNS within 72 hours Protocol for Residents receiving fast acting diabetic medication will now be given those medications as indicated by type and time before meals, and after. NG/G tube fed Residents have been identified and clear protocol via</p> <p>MD orders has been established to ensure that medication administration does not interfere with tube feeding protocols.</p> <p>The DNS will review all new orders and existing orders for new admissions, and readmissions to ensure quality medication delivery, weekly x 4 weeks x 3 months. DNS will review compliance practices with nurses administering medication for Diabetic and tube fed Residents.</p> |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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| NAME OF PROVIDER OR SUPPLIER<br><br>BELL MOUNTAIN VILLAGE & CARE CENTER |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>706 SOUTH MAIN STREET<br>HAILEY, ID 83333 |   |   |
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| {F 281}   | <p>Continued From page 2 lower extremities.</p> <p>The February 2015 physician recapitulation orders documented the resident was to receive "Sinemet 25-250 mg 1 tablet via gastrostomy tube tid (three times a day), watch for increase movement, more fluid movement, less stiffness and spasticity."</p> <p>The "Nursing 2013 Drug Handbook, page 810, Administration P.O. documented, * Give drug {Sinemet} with food to reduce GI upset, but avoid giving with high-protein meals, which can impair absorption and reduce effectiveness."</p> <p>The February 2015 recapitulation orders documented the resident was to receive, "Jevity 1.5 {high protein liquid formula} at 148 millimeter per hour to be on at 7 am off at 9 am, on at 12 pm and off at 2 pm and on at 5 pm and off at 7 pm."</p> <p>The dietitian documented in a progress note on 12/15/14 at 4:05 p.m., "...Protein can interfere with the uptake of Sinemet. Recommend scheduler {sic} Sinemet 1 hour before 2 hours after tube feeding..."</p> <p>On 2/10/15 at 7:10 p.m., an LPN was observed preparing the Sinemet medication. The LPN went into the resident's room, stopped the tube feeding that was running via a pump, administered the Sinemet medication, then restarted the feeding.</p> <p>The Administrator, DON, ADON and dietitian were informed about both observations and recommendations on 2/11/15 at 5:00 p.m. There was discussion at the meeting about the dietitian</p> | {F 281}  |   |   |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                        |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>135069 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                      | (X3) DATE SURVEY COMPLETED<br><br>R-C<br>02/12/2015 |
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| {F 281}   | Continued From page 3<br>recommendations and nursing had not in the past brought recommendations to the attention of the physician. There was discussion about the time changes to the evening insulins. No further information provided.   | {F 281}  |  |                      |   |
| {F 323}<br>SS=E   | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, it was determined the facility failed to ensure harmful chemicals and razor blades were secured in an unlocked shower room and in an unlocked closet in the tub room. This was true for 1 of 1 shower rooms and 1 of 1 tub rooms. This failure created the potential for harm for any independently mobile, cognitively impaired resident who could access the unsecured chemicals and hazards. Findings included:<br><br>On 2/9/15 at 11:28 AM, the shower room was observed to be unlocked. In the shower stall, hung on the wall, was a bottle of disinfectant bathroom cleaner which documented, "Keep out of reach of children-caution" and "Hazardous to humans." Inside the shower room was an open door to a toilet with another open door which led to the tub room. The tub room's door which lead | {F 323}  | F323 – All Nursing staff were in serviced by the DNS on 2/17/2015 about locking the shower cabinets where potentially hazardous materials are stored and locking the shower door after each shower.<br><br>Since moving to our new facility on February 27, 2015, All Residents personal shower/bathing supplies are kept in a locked cabinet at nurse's station in marked plastic boxes where other Residents cannot access them. All disinfectants and disposable razors are kept in the locked supply room where Residents cannot access them. This closet will be locket at all times.<br><br>The new facility has individual showers in each room, and the staff will get the supply's they need from the locked storage area prior to providing or assisting a resident for a shower or bath. After the shower or bath the CAN will go back to the locked storage closet and get the disinfectant cleaner and clean the shower chair | 3-20-2015            |   |

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| {F 323}   | Continued From page 4<br>to the hallway was also found to be unlocked. Next to the door, in the tub room, was a cabinet with an unlocked padlock which hung on the door. Next to the lock was a sign which documented, "Closet doors must be locked at all times." Inside the cabinet were several shelves with resident's grooming items along with a box which contained more than 50 individual razor blades.<br><br>On 2/9/15 at 11:35 AM, the DON was shown the unlocked doors. When shown the disinfectant spray, she stated, "Oh, dear." When shown the unlocked cabinet, she stated, "So it's obviously not locked." She opened the door into the hallway and asked another staff member to lock the room doors and the cabinet door.<br><br>On 2/10/15 at 7:35 PM, the Administrator, DON, and Regional Operations Director were informed of the issues. No further information was provided by the facility. | {F 323}  | Regular focused rounding by all staff will ensure that all potential hazardous material are secure. Staff will audit shower rooms, storage rooms and resident personal bathrooms every week x 4 weeks x 3 months   |                      |   |
| {F 329}<br>SS=D   | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>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 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.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not  | {F 329}  | F329 – Resident #14's Medication regimen and MD orders were reviewed with the MD in person and resident #14 was reassessed to determine whether this was an appropriate medication for resident #14 and it was determined, that resident #14 required said medication and a tracking sheet for number of hours slept has been added to the MAR to justify the continued use of Melatonin, which is an over the counter medication used for insomnia. | 3/6/2015             |   |

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| {F 329}   | <p>Continued From page 5</p> <p>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:<br/>Based on record review and staff interview, it was determined the facility failed to monitor hours of sleep for an insomnia medication. This was true for 1 of 9 (#14) sampled residents. This deficient practice had the potential for more than minimal harm if the resident received duplicate medications for insomnia based on the lack of monitoring. Findings included:</p> <p>Resident #14 was admitted to the facility on 7/18/14 with multiple diagnoses including depression and osteoporosis.</p> <p>The resident's Physician Orders, dated 7/18/14, documented an order for 3 MG of Melatonin at bedtime with a diagnosis of insomnia.</p> <p>The resident's Insomnia care plan, dated 7/18/14, documented a goal and intervention of, "Resident to sleep at [sic] 6 hours at night without interruption" and "Resident is prescribed Melatonin."</p> <p>The resident's February 2015 MAR documented</p> | {F 329}  | <p>All Residents medical records receiving Melatonin or other Medication for Insomnia have been reviewed to verify that there sleep is being tracked in the MAR along with the administration of sleep medications and that each resident's drug regimen is free from unnecessary drugs.</p> <p>Training was provided to the nursing staff from the DNS on March 6, 2015 to explain the rational of why tracking hours of sleep was required as well as ensuring that unnecessary medications were not being given.</p> <p>The DNS will review all Residents receiving Sedatives and Hypnotics for sleep upon admission, readmission, and during quarterly psychotropic reviews.</p> <p>Weekly rounding by the DNS of each Resident's MAR will ensure that all hours of sleep are being tracked daily by the nursing staff. This audit will occur weekly times four weeks times 3 months.</p> |   |

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| {F 329}   | Continued From page 6<br>the resident had received the order as directed.<br><br>On 2/12/15 at 8:40 AM, the DON was interviewed. She was asked where hours of sleep monitors were found in the medical record. She looked at the record and then stated, "I'm not seeing it."<br><br>On 2/12/15 at 2:15 PM, the Administrator, DON, and Regional Operations Director were informed of the issues. No further information was provided by the facility. | {F 329}  |   |   |

Bureau of Facility Standards

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| {C 000} | 16.03.02 INITIAL COMMENTS<br><br>The following deficiencies were cited during a follow-up to a complaint investigation survey of your facility.<br><br>The surveyors conducting the survey were:<br>Arnold Rosling RN, BSN QMRP, Team Coordinator<br>Brad Perry LSW<br><br>The survey team entered the facility on February 9, 2015 and exited on February 12, 2015.   | {C 000} | <p style="text-align: center;">RECEIVED<br/>MAR 27 2015<br/>FACILITY STANDARDS</p> <p>C - 268 - Bell Mountain Village &amp; Care Center has currently hired a staff member who is working in Dietary at this current time and was a CDM in Utah for 13 years and Utah replaced having CDM's with Safe Serve certification which she currently has and it is currently active in the state of Utah. My current staff member working in Dietary has paid and set up for her testing to re-certify for her CDM on March 10, 2015 and the courses start's on April 6, 2015. She has seven modules to take at her pace and we are giving her 10 days to complete each modules and this will take 90 days to complete. The registered Dietician will continue to come to the facility every two months to provide oversight. Our expected date of compliance will start after 90 days from the date her classes start. The facility will notify Idaho Department of Bureau Of facility Standards when she obtains her license.</p> |         |
| {C 268} | 02.107.01 Dietary Service<br><br>107. DIETARY SERVICE.<br><br>01. Dietary Supervision. A qualified food service supervisor shall be designated by the administrator to be in charge of the dietary department. This person shall:<br>This Rule is not met as evidenced by:<br>Based on record review and staff interview, it was determined the Dietary Manager (DM) failed to meet the State of Idaho qualifications to be the Food Service Supervisor (FSS). This had the potential to affect all residents in the facility. Findings included:<br><br>On 2/9/15 at 10:00 AM, during the entrance conference with the Administrator, the FSS's credentials were requested and received within the hour. The Registered Dietitian (RD) was listed as the FSS.<br><br>On 2/9/15 at 10:10 AM, the DM and RD were interviewed. The DM said she was not certified because she was in classes to become certified. | {C 268} |  | 3/20/15 |

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Adri Lucero*

TITLE  
NHA

(X6) DATE  
3/11/15