



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

April 8, 2015

Brian V. Sawyer, Administrator
Valley Vista Care Center of Sandpoint
220 South Division
Sandpoint, ID 83864-1759

Provider #: 135055

Dear Mr. Sawyer:

On **March 27, 2015**, a survey was conducted at Valley Vista Care Center of Sandpoint 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided 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) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) 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.**

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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 21, 2015**. Failure to submit an acceptable PoC by **April 21, 2015**, may result in the imposition of civil monetary penalties by **May 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; and
- 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 (if applicable).

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **May 1, 2015 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **May 1, 2015**. A change in the seriousness of the deficiencies on **May 1, 2015**, may result in a change in

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the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 1, 2015** includes the following:

Denial of payment for new admissions effective **June 27, 2015**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 27, 2015**, if substantial compliance is not achieved by that time.

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 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. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **March 27, 2015** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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:

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<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:

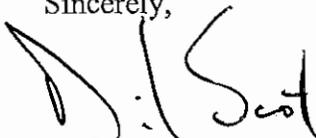
- BFS Letters (06/30/11)

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

This request must be received by **April 21, 2015**. If your request for informal dispute resolution is received after **April 21, 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 survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option 2.

Sincerely,



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

DS/dmj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

135055

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____
B. WING _____

RECEIVED
JUN 1 2015
FACILITY STANDARDS

(X3) DATE SURVEY COMPLETED

03/27/2015

NAME OF PROVIDER OR SUPPLIER

VALLEY VISTA CARE CENTER OF SANDPOINT

STREET ADDRESS, CITY, STATE, ZIP CODE
220 SOUTH DIVISION
SANDPOINT, ID 83864

(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	F 000		
F 151 SS=C	<p>The following deficiencies were cited during the facility's Annual Recertification Survey of your facility.</p> <p>The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Lauren Hoard, RN, BSN Linda Hukill-Neil, RN Becka Watkins, RN</p> <p>The survey team entered the facility on 3/23/15, and exited the facility on 3/27/15.</p> <p>483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL</p> <p>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.</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: Based on review of the facility's admission pack and staff interview, it was determined the facility failed to ensure residents were informed of their right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising their rights. This affected all sample residents (#s 1-15), 1 Random Resident (#16) and all other residents residing in the facility. This practice created the potential to negatively affect the residents' psychosocial well-being if they were not informed or allowed to exercise their rights as citizens. Findings included:</p>	F 151	<p>Preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because the provisions of the Federal and State laws require it. This provider does not maintain that the alleged deficiencies do not individually, or collectively, jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the provider asserts that it is in substantial compliance with regulations governing the operation and licensure of long term care facilities, and this Plan of Correction, in its entirety, constitutes this providers allegation of compliance.</p> <p>Completion dates are provided for the procedural procession purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in compliance with requirements of participation or that corrective action was necessary.</p>	<p>BVS 5/27/15 5/22/15 4/11/15</p>

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

Bruce V. Sawyer

TITLE
N/A

(X6) DATE
4/11/15

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 participation.

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2015	
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF SANDPOINT		STREET ADDRESS, CITY, STATE, ZIP CODE 220 SOUTH DIVISION SANDPOINT, ID 83864		
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F 151	<p>Continued From page 1</p> <p>The Facility's Admission Agreement and Resident's Bill of Rights, revised on 3/10/2010, were reviewed. The following information was not found in the Resident's Bill of Rights: * Right to be free from interference, coercion, discrimination and reprisal from the facility in exercising his or her rights.</p> <p>On 3/25/15 at 12:27 PM, Resident Services (RS) was interviewed about the admission packet. When asked about residents' right to be free from interference, coercion, discrimination and reprisal, the RS stated, "I don't see it either," and after further review the RS stated, "Yes, I don't see it."</p> <p>On 3/25/15, additional information was provided which documented, "#4. Right to be free from interference, coercion, discrimination and reprisal: Our admission agreement includes several attachments that are checked off as they are reviewed, and contains signed acknowledgement of receipt of that information. Resident Rights are one such attachment. Several items reference rights of the residents to make complaints, contact agencies acting as client advocates, access their physician, government agencies, the ombudsman, file complaints, advocate for improvements in resident care, organize and participate in resident groups, etc. In particular - #2 of our Resident Rights states the resident's right to 'present grievances to staff, administrator, government official or any other person WITHOUT FEAR OF REPRISAL, and to join with other residents or individuals within or outside of the facility to work for improvements in Resident care. ...' In addition, the Compliments, Concerns and Grievances</p>	F 151	<ol style="list-style-type: none"> Residents #1 – 16, and all other residents, were identified as having the potential to be affected by omitting specific language in the Residents' Bill of Rights provided in the facility's admission packet that all residents have "the right to be free from interference, coercion, discrimination and reprisal from the facility for exercising the residents' rights." No residents were identified as having been subjected to any actual interference, coercion, discrimination or reprisal from the facility as a result of exercising their resident rights. The Residents' Bill of Rights document provided in the facility's admission packet was revised on 4/20/2015 to include "The right to be free from interference, coercion, discrimination and reprisal from the facility for exercising the residents' rights." Residents #1 – 16 were presented with the new Residents' Bill of Rights at the resident council meeting on 4/20/2015. The residents not attending the resident council meeting were presented the updated Residents' Bill of Rights during in-room visits made the same day. The new Residents' Bill of Rights was also mailed to all guardians or POAs of facility residents on 4/20/2015. All admission packets distributed after 4/20/2015 contain the revised Residents' Bill of Rights document. 	<p>4/20/15 5/1/15 NS</p>

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F 151	Continued From page 2 attachment to our Admission Agreement, under #1., states 'Any Resident, his or her Responsible Party, family member, or appointed advocate may file a compliment, grievance or complaint concerning treatment, medical care, behavior or other residents, staff members, ...property, etc. WITHOUT FEAR OF THREAT OR REPRISAL IN ANY FORM.' We do not include the words 'interference, coercion or discrimination' in these notices, but there is no mandate they be used verbatim in our materials, and the intent is absolutely clear that residents may operate to exercise their rights without THREAT OR FEAR OF ANY FORM OF REPRISAL. There are also notices posted in the facility about being an 'equal housing' and noticing residents of the prohibition of any discrimination in the facility. This...not going to address admission agreement requirements however." On 3/26/15 at 1:08 PM, the RS and the Cooperate Consultant were asked how residents knew they had the right to be free from interference, coercion and discrimination when exercising their rights, not in relation to grievances. The RS said verbal discussion during the admission process. No documentation of such discussions were provided.	F 151	3. In-servicing for staff on the requirement to make the specified change to the Residents' Bill of Rights was done from 4/14/2015 through 4/20/2015. 4. The Resident Care Coordinator or her designee will audit all new residents' signed admission paperwork each of the next 3 months to assure all new residents have received and acknowledged the revised Residents' Bill of Rights upon admission to the facility. The Resident Care Coordinator or her designee will also report for the next 6 months at QA review whether any efforts made by any residents to exercise their rights have resulted in any complaints by residents that the facility staff exercised interference, coercion, discrimination or reprisal in their exercise of their resident rights.		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and	F 248			

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F 248	<p>Continued From page 3 the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to provide a meaningful activities program designed to meet the interests and needs for a resident on the men's unit. This was true for 1 of 15 (#6) sampled residents. The deficient practice had the potential for harm if residents experienced mood changes, increased anxiety, and/or agitation resulting from inactivity and/or boredom. Findings included:</p> <p>Resident #6 was admitted to the facility on 4/17/13 with multiple diagnoses, including Traumatic Brain Injury (TBI), hemiplegia/hemiparesis, and seizure disorder.</p> <p>The Annual MDS, dated 12/16/14, coded the resident had the ability to hear others, did not speak, was rarely/never understood and rarely/never understood others. Staff assessment of his activity preferences included: reading newspapers, books, or magazines; listening to music; being around animals; doing things with a group of people; spending time away from the nursing home; spending time outdoors; and participating in religious activities.</p> <p>The current Activity Care Plan documented, "Resident #6 has expressed the importance of following daily and weekly activities such as: being read to, playing games/bingo, watching TV in his room/day room, observing others, and sensory [activities]. Resident #6 likes</p>	F 248	<p>1. Resident # 6 had an activity re-assessment done and an activity care plan update was done to assure that meaningful activities were available to him. Staff were then made aware of his schedule and the need to invite him to participate in all scheduled activities.</p> <p>2. All residents have the potential to be affected. In servicing began for staff on resident activity needs on 4/14/2015 and continued through 4/24/2015 to educate and remind staff that resident activities must be meaningful for each resident and that residents must be offered the opportunity to participate in appropriate activities. The Activity Director performed quality assurance reviews each week starting 4/15/2015 of sample groups of residents to identify if residents are systematically being offered and engaged in meaningful activities based on their preferences. On May 1, 2015, it was determined a final house audit of all residents would be performed on May 4, 2015 to assure activities assessments matched residents' care plans and that activities offered were meaningful to each resident. After this process was completed, a specialized program was put in place on May 7, 2015 for residents identified who will not or cannot effectively plan their</p>	<p>4/20/15 5/1/15 NS</p>	

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NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF SANDPOINT	STREET ADDRESS, CITY, STATE, ZIP CODE 220 SOUTH DIVISION SANDPOINT, ID 83864
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F 248	<p>Continued From page 4</p> <p>80's rock music, watching football, out of facility activities and rides, and enjoys being outside when the weather is nice."</p> <p>The following was observed each day from 3/23/15 through 3/26/15:</p> <ul style="list-style-type: none"> - 7:30 AM, until 10:00 AM the resident was in bed; - 10:00 AM, the resident was placed in his wheelchair and taken to the TV room; - 10:00 AM until 2:00 PM, the resident sat in the TV room. - Between 1:00 PM and 2:00 PM, while in the TV room, the CNA and/or the OTA student were observed removing the resident's seat belt and chest restraint for 10 minutes, re-fasten the belt and restraint and walk away without verbally interacting with the resident. - 2:30 PM, the resident was taken back to his room and placed in his bed. <p>Throughout the above observations from 3/23/15 through 3/26/15, several activities were provided for residents to participate in, however the Activity Department and/or nursing staff were not observed to engage Resident #6 in any meaningful activities as directed by the resident's care plan to include: listening to 80's music, going on outings outside of the facility, and or having stories/books read to him.</p> <p>The resident's most recent quarterly Activity Evaluation, dated 3/9/15, documented the resident had participated in one-to-one programs and/or one-to-one visits two times a week during the previous quarter.</p> <p>On 3/27/15 at 9:20 AM the Administrator was notified of the above concerns and said the Activity staff interacts with the resident one-to-one</p>	F 248	<p>own activity pursuits, and for those needing specialized or extended programming, to enhance their daily routines and activity needs. The specialized program creates an individualized calendar for this group of residents that is broken down into specific hours and specifies the type of activity encounter that has been attempted, the resident's specific response and the duration of the encounter.</p> <p>3. The Activity Director, or her designee, is performing 5 days a week audits for the first three weeks that the specialized program is in place to assess its effectiveness and proper adherence to the program. Thereafter, weekly audits will continue to maintain this program and adapt it as may be needed. For other residents, ongoing monitoring will occur by the Activity Director, or her designee, performing activity assessments and reassessments on admission, through quarterly care assessments and care conferences with the resident and family, annually and with any significant changes. Weekly quality assurance reviews will also be done to assess resident participation in activities offered and that the activities offered are meaningful to the resident. The activity calendar will be modified and updated to reflect these quality assurance reviews and the staff will be presented with any activity changes made.</p>	
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F 248	Continued From page 5 during in-room visits. The Administrator stated he would need to contact the Activities staff to determine how often one-to-one room visits are completed and what activity is provided. The Administrator stated he would provide the information to the Bureau of Facility Standards by 3/30/15, however no additional information was received.	F 248	<p>Staff will receive a daily "Activity List" based on resident preferences to help assure invitations to residents to participate are made. Resident Council will be asked quarterly to review whether activities offered meet resident preferences and that invitations to participate are regularly made by staff.</p> <p>4. The Activity Director, or her designee, will report to the Quality Assurance review committee on these programs each month. The Activity Director and the Administrator will review the monthly activity calendar with the Quality Assurance Review Committee each month.</p>		
F 281 SS=E	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, it was determined the facility failed to ensure incontinence care was provided to male residents in the facility. This was true for 2 of 7 sampled male resident's (#s 5 & 6) and had the potential to affect any male resident living at the facility. This failed practice created the potential for harm if male residents developed urinary tract infections and/or adhesion of skin surrounding the head of the penis, requiring surgical intervention. Findings include:</p> <p>1. Resident #6 was admitted to the facility on 4/17/13 with multiple diagnoses, including Traumatic Brain Injury (TBI), hemiplegia/hemiparesis, and seizure disorder.</p> <p>The Annual MDS, dated 12/16/14, coded the resident was totally dependent on two people for toileting, always incontinent of bladder and bowel, had functional limitation in the upper extremity on</p>	F 281			

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F 281	<p>Continued From page 6</p> <p>one side and functional limitation on both sides of his lower extremities.</p> <p>The most recent Bowel and Bladder care plan documented the resident was to be checked and changed every hour and staff were to provide "excellent peri-hygiene."</p> <p>Perry, A. G., Potter, P. A., & Ostendorf, W. R., (2014). Clinical Nursing Skills & Techniques: Procedural Guideline 17-1. Perineal Care, 403, 403-404, documented: Providing peri-care on male residents: - Gently raise penis and grasp the shaft; - If the resident is uncircumcised, retract foreskin; - Wash tip of penis at urethral meatus first. Using circular motion, clean from meatus outward; - Rinse/dry thoroughly and return foreskin to its natural position; and - Clean shaft of penis and scrotum, lift scrotum and wash underlying skin folds, and rinse and dry thoroughly.</p> <p>On 3/24/15, at 10:10 AM, CNA #1 and CNA #2 were observed providing incontinent care for Resident #6. The CNAs removed the urine soaked incontinent brief and applied a new brief without providing peri-care to the resident's penis, scrotum, the skin folds under the scrotum and/or meatus. The resident's pants were pulled up and the resident was placed in his wheel chair.</p> <p>On 3/25/15, at 2:30 PM, CNA #3 and CNA #4 were observed providing incontinent care for Resident #6. The CNAs removed the urine soaked incontinent brief and applied a new brief without providing peri-care to the resident's penis, scrotum, skin folds under the scrotum and/or the meatus. The resident was covered with a blanket</p>	F 281	<p>1) Staff re-training on appropriate incontinence care began following facility notification. Audits for proper pericare were initiated at that time. Residents #5 and #6 were among the residents audited for proper pericare. Care plans were updated to read "two person assist to assure proper pericare is received."</p> <p>2) All incontinent residents requiring assistance have the potential to be affected by this issue. Incontinent residents within the facility were identified and routine observation of incontinent care, including peri-hygiene, was initiated. Through admit assessment, quarterly MDS review, and PRN status review, additional at risk residents will be identified.</p> <p>3) In-servicing was done for nursing staff on proper incontinence care beginning on 4/14/15 and will be ongoing. The DNS or designee will perform weekly QA rounds consisting of observation of staff to ensure ongoing compliance with facility policies and professional standards in relation to incontinence care. Weekly rounds will be performed for four weeks and then monthly for three months beginning on 4/15/15. Additionally, a CNA skills lab will be conducted at least annually to review proper care techniques, and</p>	<p>4/24/15 5/1/15 NS</p>	

Added per Administrator's request
per phone call on 3-28-15 @ 3:40 PM NS
L Kelly

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/27/2015
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF SANDPOINT		STREET ADDRESS, CITY, STATE, ZIP CODE 220 SOUTH DIVISION SANDPOINT, ID 83864		
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F 281	<p>Continued From page 7 and left in bed.</p> <p>On 3/25/14, at 2:40 PM, when asked if peri-care was provided to the resident's penis, scrotum, skin folds under the scrotum, and/or meatus. CNA #3 and CNA #4 stated peri-care was not performed and CNA #3 stated, "We will go back in and do it now."</p> <p>On 3/27/15, at 9:20 AM, when asked to describe proper peri-care on male residents and when it should be completed, the Administrator said peri-care should be completed anytime a resident has a soiled incontinent brief, and more often if necessary. He stated the proper technique for cleaning a male's penis is to pull the foreskin back, clean the head of the penis, replace the foreskin, and clean the shaft of the penis. The administrator was informed of the above observations and confirmed proper peri-care was not performed on Resident #6.</p> <p>2. Resident #5 was admitted to the facility on 8/3/13 with multiple diagnoses, including multiple sclerosis, paraplegia, muscle weakness, knee contracture, and pressure ulcer.</p> <p>The most recent Quarterly MDS assessment, dated 1/26/15, coded the resident was totally dependent on two people for toileting, frequently incontinent of urine, and always incontinent of bowel.</p> <p>The most recent Bowel and Bladder care plan documented the resident needed to be checked and changed every two hours and as needed, and provided peri-hygiene with barrier cream.</p> <p>On 3/25/15, at 2:25 PM, CNA #3 and CNA #4</p>	F 281	<p>will require CNAs to perform return demonstration, to observe that they are fully aware of what is required when performing incontinence care.</p> <p>4) The DNS or her designee will follow this issue through weekly QA observations rounds as stated above and report monthly to the QA committee. After 3 months, the QA committee will determine the need for ongoing auditing and frequency.</p>	

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F 281	<p>Continued From page 8</p> <p>were observed providing incontinent care for Resident #5. The resident was rolled side to side and the urine soaked incontinence brief was removed. The CNAs applied cream to the resident's buttocks, rolled the resident onto his back, cleaned his groin, and placed a new incontinent brief on him. The CNAs did not provide peri-care to the resident's penis, scrotum, skin folds under the scrotum and/or meatus. Upon completion of the task CNA #3 stated, "See we remembered to provide peri-care."</p> <p>On 3/27/15, at 9:20 AM, when asked to describe proper peri-care on male residents and when it should be completed, the Administrator said peri-care should be completed anytime a resident has a soiled incontinent brief, and more often if necessary. He stated the proper technique for cleaning a male's penis is to pull the foreskin back, clean the head of the penis, replace the foreskin, and clean the shaft of the penis. The administrator was informed of the above observation and confirmed proper peri-care was not performed on Resident #5.</p>	F 281		
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 309		

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F 309	<p>Continued From page 9</p> <p>Based on observations, staff interviews, and record review, it was determined the facility failed to ensure Resident #6, who had a traumatic brain injury, received daily cares and skin checks according to his individualized Care Plan and Resident #8 did not have physician ordered diabetic labs drawn. The failure to implement Resident #6's Care Plan impacted the resident's emotional and physical well being and the failure to obtain Resident #8's labs placed the resident at risk for complications related to diabetes. This was true for 2 of 13 sampled residents (#s 6 & 9). Findings included:</p> <p>1. Resident #8 was readmitted to the facility on 12/12/13 with multiple diagnoses including diabetes mellitus (DM), impulse control disorder, quadriplegia, and history of traumatic brain injury.</p> <p>The resident's 3/2015 recapitulation Physician's Orders documented: "...Metformin (Glucophage) 1000 mg by mouth twice daily (DM)...origin date 12/12/13..." "...Lab: A1C [also known as HgbA1C, glycosylated hemoglobin or glycosylated hemoglobin] every 3 months (Due Jan, April, July, Oct)...origin date 10/27/14..."</p> <p>Resident #8's medical record documented the results of the A1C drawn in October 2014, but contained no lab results for the A1C that was ordered to be drawn January 2015.</p> <p>Resident #8's 1/7/15 quarterly MDS and 10/13/14 annual MDS documented, the resident had a metabolic diagnosis related to diabetes mellitus and the resident's diet was a therapeutic and mechanically altered diet.</p>	F 309	<p>1) The missed lab for resident #8 was drawn on 4/3/15. The lab results were given to the physician upon receipt. No new orders were received from the physician. Upon facility notification, a skin check was performed on resident #6 to ensure that resident's skin was intact. No issues were noted. Staff re-training began 4/14/15 regarding the deficient practice for resident #6 and #8.</p> <p>2) All residents have the potential to be affected. Starting on 4/15/15, an audit was completed of each resident's physicians' orders to ensure that all routine labs have been completed as ordered. This was completed by 4/28/15. Additionally, CNA compliance with adhering to the care plan will be randomly audited on a weekly basis for three months by the DNS or her designee, beginning on 4/14/15. Any staff member who fails to follow the care plan will receive an immediate on the spot correction. Through admit assessment, quarterly MDS review and prn change of status review residents will be identified for care planning update needs.</p>	<p>4/24/15 5/1/15 NS</p>

*per fax dated 4/10/2015
from administrator NS*

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F 309	<p>Continued From page 10</p> <p>The resident's current Care Plan did not contain a problem area for diabetic care directives, nor goals and interventions.</p> <p>Resident #8's March 2015 MAR documented Metformin 1000 mg by mouth twice daily was administered 3/1/15 through 3/24/15 for DM.</p> <p>On 3/26/15 at 4:00 PM, the DNS was interviewed regarding the resident's January A1C lab order and how the facility ensured diabetic care orders were followed. The DNS stated, "The A1C that was to be drawn in January was not drawn." The DNS acknowledged the lab order should have been on the January 2015 MAR/TAR to have alerted staff, the resident was due for the lab testing for his diabetes.</p> <p>On 3/26/15 at 4:30 PM, the Administrator and DNS were informed of the issues. There was no additional information provided to alleviate the concerns.</p> <p>2. Resident #6 was admitted to the facility on 4/17/13 with multiple diagnoses to include traumatic brain injury (TBI), hemiparesis, seizure disorder, depressive disorder, and anxiety neurosis.</p> <p>The Annual MDS, dated 12/16/14, coded the resident had the ability to hear others; did not speak, was rarely/never understood and rarely/never understood others. He required total assistance of two staff or more for transfers, dressing, toileting, and showers, and extensive assist of two staff for bed mobility. He had functional limitation in range of motion in both lower extremities, and one upper extremity.</p> <p>The resident's current care plan documented:</p>	F 309	<p>3) In-servicing done for nursing staff on the importance of following residents' care plans and physicians' orders began on 4/14/15 and continued through 4/24/15. Moving forward, all routine labs will be scheduled within the first two weeks of the month for which they are ordered. The DNS or designee will audit each of the resident's medical records during the third week of the month to ensure that all labs have been drawn and results have been received and filed. Any noted omission will be scheduled to be drawn prior to the end of the month. The DNS or designee will perform weekly quality assurance reviews on a sample group of residents and will observe and ensure that cares are rendered in accordance with residents' plan of care. These weekly rounds will continue for three months. Additionally, CNA skills lab will be performed at least annually, and will consist of review of proper technique of specific cares, as well as a review of the importance of providing cares in accordance with each residents' established plans of care.</p> <p>4. The DNS or her designee will report on these issues in monthly QA committee where it will be determined if ongoing audits need to be continued after completion of the next three months of weekly random audits.</p>	

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F 309	<p>Continued From page 11</p> <ul style="list-style-type: none"> - Explain all tasks before doing them and each step as it is done; - Resident #6 is less combative when he is allowed to lie on his back during cares, versus being rolled side to side; - Do not startle resident as it will cause increased agitation; - If resident becomes combative with cares, give [him] space and allow him to calm down before re-approaching; - Resident is a two person assist with showers due to striking out; and - Check skin under the restraints every two hours when restraints are released. <p>The following was observed on 3/24/15:</p> <ul style="list-style-type: none"> - 10:10 AM, CNA #2 and CNA #1 went into the resident's room to get him dressed and up in his wheelchair for the day. The CNAs gathered the resident's clothes and supplies to change his incontinent brief. The CNAs rolled the resident on his left side and placed his left arm, head/neck into his shirt and he began to slap CNA #2's arm. CNA #1 stated, "Resident #6 we are going to roll you over." The CNAs continued to roll the resident left and right at a "fast/rushed" pace to complete cares. Resident #6 slapped his left thigh (leaving a reddened area) and slapped the CNAs arm faster and more forcefully. While the hoier sling was placed under the resident and attached to the hoier lift Resident #6 flailed his arms and pinched/slapped at his right right breast/side and reached his left arm outside of the sling. CNA #1 stated, "We are just trying to get you up Resident #6! Resident #6 get your hand in[side the sling]! Resident #6 get your arm in[side the sling]!" The resident continued to flail his arm while he was transferred from his bed to his wheelchair. CNA #1 stated, "It is okay Resident #6 we are almost 	F 309		

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F 309	<p>Continued From page 12</p> <p>done." The hoyr sling was removed from underneath the resident and his chest restraint and seatbelt were applied. CNA #1 got a wet washcloth and stated, "Let's wash your face (as she was performing the task)." Resident #6 slapped/grabbed at CNA #1's arm and CNA #1 stated, "That wasn't so bad, was it." The palm protector was applied to the resident's right hand and he was taken to the TV room. The above tasks were not explained to the resident prior to performing them and the staff did not follow the care plan as directed, "If the resident becomes combative with cares, give [him] space and allow him to calm down before re-approaching." Additionally the resident's right hand was not inspected or washed prior to applying the splint, as directed by the resident's care plan.</p> <p>- 1:40 PM, CNA #2 was observed to remove Resident #6's chest restraint and seatbelt. The CNA did not explain what she was doing prior to removing the restraints.</p> <p>- 1:50 PM, CNA #2 re-attached the chest restraint and seatbelt without first explaining what she was doing which caused the resident to startle/flinch and flail his left arm. There was zero verbal interaction observed between the CNA and resident before, during, or after the restraints were released and reattached.</p> <p>The following was observed on 3/25/15: -10:10 AM, CNA #7 stated, "Resident #6 it's time for your shower." Without explanation the CNAs removed the resident's gown and attend, leaving the resident naked and exposed. The resident was observed to pull his knees up towards his chest, strike out at CNA #8, and slap his left thigh (leaving a reddened area). CNA #7 and CNA #8 rolled the resident on his left side to place the hoyr sling underneath him and CNA #8 stated,</p>	F 309		

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F 309	<p>Continued From page 13</p> <p>"[Resident #6] this is the part you don't like." The resident is lifted by the hoyer and placed in the shower chair. The resident is naked, exposed, and has his knees pulled up towards his chest. Neither CNA #7 nor CNA #8 explained the tasks to resident; recognized or acknowledged the resident was "less combative when he was allowed to lie on his back during cares, versus being rolled side to side; not to startle the resident as it will cause increased agitation; and if resident becomes combative with cares, give [him] space and allow him to calm down before re-approaching."</p> <p>- 10:15 AM, CNA #9 entered the resident's room and placed a gown on the resident and then transported him to the cold shower room. The resident was visibly agitated as evidenced by his knees drawn up towards his chest, grabbing his right foot, rubbing his right leg, and digging at his right side. Resident #6 grabbed and slapped CNA #9's arm throughout the shower. The CNA stated it was difficult to shower the resident alone and, "do a good job."</p> <p>- 10:30 AM, CNA #7 entered the shower room and asked CNA #9, "Are you doing okay in here?" CNA #9 stated, "I could use some help with his arm while I am washing him." CNA #7 asked CNA #9, "Would you like some help?" CNA # stated, "Yes, then I can do a better job cleaning him." CNA #7 took Resident #6's hand in her hand and the resident appeared to slap and grab less. The resident's care plan was not followed as it directed two staff to be present during the shower.</p> <p>- 10:45 AM, CNA #6 and CNA #7 transferred the resident out of the shower chair and into his bed via hoyer. Resident #6 moaned and grimaced as CNA #1 in a "fast/rushed" pace started rolling him side to side to dress him. Zero explanation was</p>	F 309		

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F 309	<p>Continued From page 14 provided to the resident.</p> <p>- 1:00 PM, Resident #6 was observed sitting in the TV room. His chest restraint and seatbelt were released. The Occupational Therapy student approached the resident from behind and reached around the resident to reattach the chest restraint and the seatbelt. The resident's entire body flinched, he flailed his left arm, pushed up on the wheelchair handle, slapped his head rest and jerked his knees and legs up towards his chest. The student failed to verbally interact and explain what he was doing prior to reattaching the chest restraint and seatbelt.</p> <p>- 2:30 PM, CNA #3 and CNA #4 placed the hoyer sling, in the resident's wheelchair underneath him and raised him out of the wheelchair and into his bed. The resident struck/grabbed at CNA #4's arm as he was rolled side to side to remove his pants and incontinent brief. When the soiled brief was removed and the clean brief was applied the resident slapped his left thigh (leaving a reddened area) and slapped CNA #4's arm. The above tasks were not explained to the resident prior to performing them and the staff did not follow the care plan as directed, "If the resident becomes combative with cares, give [him] space and allow him to calm down before re-approaching."</p> <p>On 3/27/15, at 9:20 AM, the Administrator was notified of the above observations. The Administrator confirmed staff should explain the task being performed prior to and throughout the process. Additionally, he stated staff should be at the resident's eye level when providing explanations and the resident was a two person assist for showers. The administrator stated the resident should be taken to his room every two hours when the restraints were released to check the skin integrity under the restraints. No</p>	F 309		

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F 309 F 323 SS=D	<p>Continued From page 15 additional information was provide to resolve the identified concerns.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure adequate supervision and safety was provided to a resident to address his toileting needs. This was true for 1 of 1 Random Resident (#16). This failed practice created the potential for more than minimal harm if the resident developed pressure related skin issues and/or attempted to self-transfer off of the toilet resulting in a fracture and requiring surgical intervention. Findings included:</p> <p>Random Resident (RR) #16 was admitted to the facility on 10/14/00 with multiple diagnoses, including traumatic brain injury (TBI), abnormal involuntary movements, and seizure disorder.</p> <p>The current Quarterly MDS, dated 2/2/15, coded the resident had the ability to understand others and to be understood by others, required two person assistance with toileting, and had functional limitation in range of motion in the right</p>	F 309 F 323	<ol style="list-style-type: none"> 1) Staff re-training regarding adequate supervision and assistance began following facility notification. Care plan adjustments were made for resident checks while on toilet for Q 5-10 minutes. Resident #16 was assisted off of the toilet. 2) All residents have the potential to be affected by this issue. An audit was completed by 4/30/15 to identify all residents within the facility who, due to their lack of reliable ability to consistently use a call light during toileting, require increased supervision. 3) In-servicing done for nursing staff on the importance of providing adequate supervision to maintain resident safety began on 4/15/15 through 4/24/15 and will be ongoing. The DNS or her designee have performed weekly QA rounds observing that identified residents are receiving sufficient supervision while toileting. Weekly rounds have been and will be performed for four weeks and then monthly for three months beginning on 4/15/15. Based on auditing results above, a discrete labelling system was initiated on 5/4/15, by which these residents are now easily identifiable to direct care staff, making them aware of the need for increased supervision when toileting. 	<p>4/24/15 5/1/15 NS</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/27/2015
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF SANDPOINT		STREET ADDRESS, CITY, STATE, ZIP CODE 220 SOUTH DIVISION SANDPOINT, ID 83864		
(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 323	<p>Continued From page 16 upper and right lower extremity.</p> <p>The current care plan documented RR #16 was to be placed on the toilet after meals and every 2 hours while awake. The care plan did not document the amount of supervision the resident required while sitting on the toilet or how often he should be checked.</p> <p>The following observations were made on 3/25/15:</p> <ul style="list-style-type: none"> - 9:10 AM, CNA #5 assisted RR #16 onto the toilet after breakfast, placed the call light cord on top of the toiletpaper holder to the left of the resident. The resident had impairment in his left upper extremity, including contractures of his left hand and fingers. The CNA left the bathroom door open approximately four inches, left the resident's room, and pulled the bedroom door shut. - 9:30 AM the bedroom door was shut and RR #16 was still on the toilet. The surveyor entered the resident's room and the resident yelled, "Get me off of here!" - 9:35 AM, CNA #5 walked by RR #16's room and did not stop to check on the resident. - 9:43 AM, CNA #8 knocked on the resident's door and entered the resident's room to fill his ice water. The resident yelled, "Get me off of the toilet, please!" CNA #8 acknowledged the resident and stated she would be back with another CNA to help. - 9:45 AM, CNA #8 and CNA #7 returned to the resident's room and the resident yelled, "Get me off of this D*** (profanity) toilet!" The surveyor asked and was told by the resident that he could reach his call light. The surveyor asked the resident to show her. The resident with difficulty reached across his abdomen with his right hand, 	F 323	<p>4) The DNS or her designee will perform weekly quality assurance rounds observing that identified residents are receiving sufficient supervision while toileting. Weekly rounds will be conducted for four weeks from 4/15/2015, and then monthly for three months. The DNS or her designee will report findings monthly to the Quality Assurance Committee and after three months the Committee will determine the need for ongoing auditing. Through admit assessment, quarterly reviews and prn status change reviews, any additional residents that require increased supervision will be identified, their care plans updated and to be included in the discreet labeling system noted above."</p>	

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F 323	Continued From page 17 reached up on top of the toiletpaper holder, and pulled the call light cord. - 10:00 AM, CNA #8 stated, "Sometimes [the resident] needs to sit on the toilet for 'awhile' before he is able to have a bowel movement." CNA #8 confirmed the bathroom call light cord was not placed within the resident's reach and stated, "He doesn't remember to pull the cord anyway." On 3/27/15 at 9:15 AM, the DNS was informed of the above observation. The DNS stated, "Up to this point the resident had not tried to self transfer and has been able to use the call light." She stated the resident was toileted after breakfast and would need to sit on the toilet for "awhile." The DNS did not clarify what "awhile" referred to, however she did state, "It would not hurt to check on the resident more often" when he was placed on the toilet.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328		

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F 328	<p>Continued From page 18</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents with oxygen therapy had completed oxygen saturations with the correlating liter flow documented on the Treatment Administration Records (TAR), received the correct physician-ordered liter flow rate, and had care plans which directed care in relation to oxygen therapy. This was true for 2 of 13 sampled residents (#s 9 & 12) reviewed for oxygen therapy. This created the potential to cause respiratory problems related to incorrect administration of oxygen and a drop in oxygen saturation levels causing residents to become anxious, confused or experience respiratory distress. Findings included:</p> <p>The facility's Oxygen Administration Policy and Procedure, revised October 2010, documented, "The purpose of this procedure is to provide guidelines for safe oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident..."</p> <p>1. Resident #12 was admitted to the facility on 1/14/15 with multiple diagnoses which included COPD (Chronic Obstruction Pulmonary Disease), CHF (Congestive Heart Failure) and dyspnea.</p> <p>Resident #12's most recent admission MDS assessment, dated 1/22/15, documented the resident was cognitively intact with a BIMS of 15, displayed no behaviors, required extensive assistance with bed mobility, dressing, bathing and toilet use. The resident received oxygen therapy while he was not a resident and while he</p>	F 328	<ol style="list-style-type: none"> 1. Resident #9 was placed on 3 liter oxygen flow per physicians' orders and was properly oxygenated per the resident's care plan on oxygen therapy. Resident #12 was checked to be sure oxygen therapy being given matched the physician's orders and the care plan, and that proper oxygenation was being achieved. Resident #12 was offered ear padding for her nasal cannula, however she refused them, stating that she did not like them. MD was faxed upon notification, and padding was discontinued. 2. All residents with oxygen therapy orders have the potential to be affected by this issue. An audit was completed by 4/24/2015 of all residents with oxygen therapy orders to ensure these residents are being given the proper oxygen liter flow as ordered by their physician and their resident care plans match the physician orders and include other associated needs related to oxygen therapy. 	<p>4/24/15 5/11/15 MD</p>
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F 328	<p>Continued From page 19 was a resident in the facility.</p> <p>The Potential for/Actual Altered Breathing Patterns Care Plan, documented the plan was related to end stage COPD, severe SOB (Shortness of Breath), A-Fibrillation, CAD (Coronary Artery Disease), and CHF (Congestive Heart Failure). The "Exhibited By" space was blank. The interventions included meds as ordered; report unrelieved SOB to MD for further evaluation; encourage rest periods during tasks PRN (as needed), O2 if ordered; and "Pt. may self administer nebulizer treatments once LN sets up (3/23/15)."</p> <p>Resident #12's March 2014 recapitulated Physician's Orders included the order, "O2 [Oxygen] per N/C [Nasal Cannula] to keep O2 sats [saturation] > or = 90%. May titrate 1-4 L [Liters]. O2 sats to be checked Q [every] shift (Hypoxia)," with a start date of 1/14/15.</p> <p>The January, February and March 2015 TAR for Resident #12 documented the aforementioned Physician's Order with spaces in which LN's write their initials, the oxygen saturations and oxygen liter flow. On the following dates and shifts, information was not documented on the TAR: * 1/15/15 night shift did not document O2 sats, liter flow or initial; * 1/21/15 night shift did not document O2 sats, liter flow or initial; * 1/25/15 evening shift did not document liter flow or initials, and night shift did not document O2 sats, liter flow or initial; * 1/26/15 day shift did not document O2 sats, liter flow or initial; * 1/29/15 night shift did not document O2 sats, liter flow or initial;</p>	F 328	<p>A second audit was done on 4/27/2015 to ensure oxygen saturation monitoring was completed and properly documented on each resident's TAR.</p> <p>3. Initial In-servicing was done on 4/14/2015 for nursing staff regarding the need to administer oxygen therapy per physician's orders and to monitor and document oxygen saturation levels to assure residents do not suffer anxiety, confusion or respiratory distress. Education will be ongoing based on audit findings.</p>	
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F 328	<p>Continued From page 20</p> <ul style="list-style-type: none"> * 1/30/15 night shift did not document O2 sats, liter flow or initial; * 2/13/15 evening shift did not document O2 sats, liter flow or initial; * 2/25/15 evening and night shift did not document O2 sats, liter flow or initial; * 2/28/15 night shift did not document liter flow or initial; * 3/7/15 evening shift did not document O2 sats, liter flow or initial; and, * 3/13/15 night shift did not document O2 sats, liter flow or initial. <p>On 3/26/15 at 2:33 PM, the DON was asked what was expected to be on the care plan for a resident receiving oxygen therapy, and she said she needed to look into it.</p> <p>On 3/27/15 at 8:27 AM, the DON said she felt Resident #12's care plan could have been more specific (NOTE: The care plan documented, "Oxygen if ordered"). At 8:35 AM, the DON was informed of the missing documentation on the TARs related to oxygen saturations, liter flow and initials. She said she would check the vital signs flow sheet to find additional documentation.</p> <p>On 3/27/15 at 9:04 AM, the DON provided a vital signs flow sheet for Resident #12 which documented oxygen saturations and liter flow for the dates of 1/15/15, 1/21/15 and 1/25/15.</p> <p>On 3/26/15 at 4:30 PM, the Administrator and DON were informed of the oxygen concerns. No further information was provided.</p> <p>2. Resident #9 was readmitted to the facility on 3/9/15 with multiple diagnoses including pneumonia, chronic obstructive pulmonary</p>	F 328	<p>4. The DNS or designee will do weekly rounds to randomly sample residents with oxygen therapy order to observe that identified residents are receiving the correct liter flow as ordered by the physician, that care plans accurately reflect oxygen therapy orders, and that oxygen saturation levels are checked and documented daily on the residents' TAR. Weekly quality assurance rounds will be performed for four weeks and then monthly for three months beginning 4/15/2015. Bi-monthly TAR audits will be done by Medical Records to identify missing O2 sat documentation to identify the staff in need of immediate instruction or corrective action. The DNS or her designee will report on these rounds to the Quality Assurance Committee at its monthly meeting, and the Committee will determine the need for and frequency of any additional sampling rounds</p>	

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F 328	<p>Continued From page 21</p> <p>disease (COPD), chronic respiratory failure, and hypoxemia. The resident had been discharged from the facility on 3/3/15 and hospitalized for pneumonia and COPD, then subsequently returned to the facility 6 days later.</p> <p>The resident's admission Physician's Orders, dated 3/9/15, documented, "...oxygen take as directed by physician-3 L [liters]..." The oxygen order did not contain nor had clarification been requested on means of oxygen delivery, parameters of oxygen saturation levels, and a oxygen titration range.</p> <p>The resident's recapitulation orders, dated 3/1/15, documented, "...Check O2 [oxygen] sats [saturation] with episodes of confusion or when found not wearing O2, record when done...origin date 11/12/13...", and "...O2 per N/C [nasal cannula] to keep O2 sats > [greater than] 88%. May titrate 1-4 L. O2 sats to be checked Q [every] shift (COPD)...origin date 2/1/15..."</p> <p>Note: The resident's recapitulation orders were documented and printed prior to her discharge from the facility on 3/3/15 to the hospital. The physician completed admission orders for the resident on 3/9/15, when she returned to the facility.</p> <p>Resident #9's admission Care Plan, dated 3/9/15, documented, "...Potential for/ actual altered breathing patterns...", with a goal of, "...Resident will have no unrelieved episodes of shortness of breath during rest daily unless clinically unavoidable...", and the interventions documented as, "...1. Meds as ordered. 2. Report unrelieved SOB [shortness of breath] to MD for further evaluation. 3. Encourage rest periods during tasks PRN. 4. O2 if ordered..." Resident's</p>	F 328		

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F 328	<p>Continued From page 22</p> <p>Skin Integrity Care Plan documented, "...At risk for/ actual impairment in skin integrity...", with a goal of, "...will not develop pressure related compromise unless clinically unavoidable during next 90 days...", and the intervention documented as, "...make sure O2 tubing is padded for protection to ears..."</p> <p>The resident's TAR, dated 3/9/15, documented, "...O2 per N/C at 3 LPM [liters per minute] as directed by physician...origin 3/9/15..." The TAR contained day, evening, and night shifts with boxes to record saturation level, liter flow rate, and nurses initials. The following documentation had been recorded:</p> <ul style="list-style-type: none"> -3/9/15 through 3/22/15: recorded O2 at 3 L, saturation > 89%, and nurses' initials. (Exception was 3/13/15 for night shift, there was no documentation for saturation, liter flow rate, and nurses' initials). -3/23/15 through 3/25/15: recorded the O2 at 2 L for the day shift, saturation >89%, and nurses' initials. -3/23/15 through 3/25/15: recorded O2 at RA (room air) for the night shift, saturation >89%, and nurses' initials. <p>On 3/23/15 at 1:10 PM, 3/25/15 at 10:05 AM, 12:45 PM, and 2:45 PM, and 3/26/15 at 8:05 AM, the resident was observed in her room and the dining room. The resident had her oxygen in place via N/C and the liter flow rate was set at 2 L. The resident's oxygen tubing was observed, without any padding for the ears, throughout the observations.</p> <p>On 3/24/15 at 8:30 AM, 11:55 AM, and 3:25 PM, and on 3/25/15 at 8:10 AM, 9:43 AM, and 2:45 PM, the resident was observed in her room, the</p>	F 328		

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328	<p>Continued From page 23</p> <p>hall, and the dining room without any oxygen being delivered via N/C, by the room air concentrator or a portable oxygen tank. The room air concentrator and/or portable oxygen tank were noted to be set at 2 L with each observation, but the resident did not have the N/C in place.</p> <p>On 3/24/15 at 11:55 AM, the resident was observed, on her bed, with the head of the bed elevated and the room air concentrator set at 2 L. The resident did not have her oxygen in place, but held the tubing without any protective padding in her hands. The resident stated, "I would die without my oxygen. I have to have it." The resident acknowledged, she did not have the oxygen on and should since she quite often would become very short of breath.</p> <p>On 3/26/15 at 4:00 PM, the DNS was interviewed regarding Resident #9's oxygen therapy. The DNS acknowledged the resident's temporary Care Plan did not document specific oxygen care directives and needed to be updated. The DNS also acknowledged the physician's orders were for oxygen delivered at 3 LPM flow rate, but had been set at 2 LPM and the oxygen tubing did not have padding for ear protection. The DNS stated these issues had now been corrected.</p> <p>On 3/26/15 at 4:30 PM, the Administrator and the DNS were informed of the oxygen concerns. No additional information was provided to alleviate the issue.</p>	F 328		
364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides</p>	F 364		

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F 364	<p>Continued From page 24</p> <p>food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on the resident group interview, a breakfast test tray, and staff interview, it was determined the facility failed to ensure food was served at a preferably adequate temperature. This was true for 4 of 7 residents in the group interview and any other resident who dined in the main dining room. This failure created the potential for a negative effect on residents' nutritional status and psychosocial well-being related to unpalatable food. Findings included:</p> <p>On 3/24/15 at 3:30 PM, two surveyors met with a group of 7 residents. When asked if hot foods were served hot, 4 of the 7 residents stated the food was cold. One resident stated, "Cold pancakes when I eat in the dining room," and another resident agreed. A third resident stated, there was a problem with cold foods overall but "mostly with breakfast," and if the food was cold, "it was not worth eating." A fourth resident expressed cold food is "occasionally an issue." All the residents stated their meals were usually on time, but the breakfast meals were late and "generally is so we expect it."</p> <p>On 3/26/15 the following breakfast events were observed: -7:25 AM: Breakfast tray line was observed. -7:50 AM: There was a pause, after one of the food carts went out to the Lodge Dining Room. The cook stated a 10 minute wait was necessary</p>	F 364	<p>1. An audit was completed of food temps and a satisfaction survey was done by the Dietary Manager with the Resident Council members and by in room visits for those not attending on or before 4/24/15</p> <p>2. All residents who receive trays from the kitchen have the potential to be affected. Proper food temperatures will be reviewed through food satisfaction surveys monthly beginning 4/14/15 for 3 months, resident council review monthly for 3 months beginning 4/14/15 and food temperature audits weekly beginning 4/14/15. Satisfaction surveys will be given to all residents receiving trays from the kitchen. The dietary staff will adjust the menu and spread speed with which food trays are delivered based on any issues raised by the auditing and satisfaction survey process.</p>	5/1/15 MS
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F 364	<p>Continued From page 25</p> <p>or the next cart would be too early and that staff needed to make more scrambled and fried eggs. The food in the hot tray line containers was left uncovered.</p> <p>-8:05 AM: Test tray prepared and placed on the food cart for the main dining room with other trays.</p> <p>-8:10 AM: The food cart was sent to the main dining room. The kitchen staff took the drink cart into the dining room first.</p> <p>-8:11 AM: The food cart was delivered to the main dining room. There were 8 residents in the main dining room and drinks were passed out first.</p> <p>-8:15 AM: The first tray was passed to a resident.</p> <p>-8:19 AM: The second tray was passed to a resident, who was yelling he was hungry.</p> <p>-8:23 AM: Wound nurse entered the dining room to assist passing the remaining trays.</p> <p>-8:28 AM: Test tray delivered to the conference room.</p> <p>The test tray included scrambled egg with mushrooms, cream of wheat, toast, and a carton of milk. The CDM, RD, and 3 surveyors evaluated the meal tray and determined the following: *Scrambled egg with mushrooms - 124.3 degrees Fahrenheit (F), consistency was satisfactory and the temperature unsatisfactory; *Cream of Wheat- 142 degrees F, flavor and temperature satisfactory; *Toast - 90.7 degrees F, flavor and temperature satisfactory; and, *Milk - 46 degrees F, flavor and temperature satisfactory.</p> <p>Upon completion of the test tray evaluation, the CDM stated the she liked the eggs' consistency, the taste was not unpleasant, but they could be a little hotter.</p>	F 364	<p>3. Inservicing done for kitchen and nursing staff on food temperatures and timely delivery of trays beginning on 4/14/15 and will be ongoing as necessary based on the results of the satisfaction survey audits and resident council discussions.</p> <p>4. The Dietary Manager or her designee will report findings on this issue at the monthly Quality Assurance Committee meeting. The QA Committee will determine if there is a need to continue weekly audits and monthly satisfaction surveys based on these reports after the initial three month period.</p>	
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F 364	Continued From page 26 On 3/26/15 at 4:30 PM, the Administrator and DNS were informed of the temperature concerns for the hot food. The facility did not provide any additional information to resolve the issue.	F 364		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001540	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2015
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NAME OF PROVIDER OR SUPPLIER
VALLEY VISTA CARE CENTER OF SANDPOINT

STREET ADDRESS, CITY, STATE, ZIP CODE
**220 SOUTH DIVISION
SANDPOINT, ID 83864**

(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
C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Annual State Re-licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Lauren Hoard, RN, BSN Linda Hukill-Neil, RN Becka Watkins, RN</p> <p>The survey team entered the facility on 3/23/15, and exited the facility on 3/27/15.</p>	C 000	<p>RECEIVED APR 21 2015 FACILITY STANDARDS</p>	
C 409	<p>02.120.05,i Required Room Closet Space</p> <p>i. Closet space in each sleeping room shall be twenty inches by twenty-two inches (20" x 22") per patient/resident. Common closets utilized by two (2) or more patients/residents shall be provided with substantial dividers for separation of each patient's/resident's clothing for prevention of cross contamination. All closets shall be equipped with doors. Freestanding closets shall be deducted from the square footage in the sleeping room.</p> <p>This Rule is not met as evidenced by: Based on the Waivers in Effect form review and Administrator interview, it was determined the facility did not provide the required personal closet space for residents in rooms 102, 108, 109, and 304. Findings included:</p> <p>The reduction in required closet size created a potential for residents to have insufficient space for storing clothing and personal items.</p>	C 409	<p>Requested continuation of waiver</p>	<p>4/24/15</p>

Bureau of Facility Standards

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

TITLE

(X6) DATE

Brian V. Sawyer RN NHA

4/20/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001540	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/27/2015
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NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF SANDPOINT	STREET ADDRESS, CITY, STATE, ZIP CODE 220 SOUTH DIVISION SANDPOINT, ID 83864
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C 409	Continued From page 1 The facility was previously granted a waiver for this requirement on 1/16/14. On 3/26/15, the Administrator was asked and confirmed the facility's continued need for the closet waivers for rooms 102, 108, 109 and room 304.	C 409		
C 422	02.120.05,p,vii Capacity Requirments for Toilets/Bath Areas vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water. This Rule is not met as evidenced by: Based on interview with the Administrator and review of the Waivers In Effect form, it was determined the facility did not provide 1 tub or shower for every 12 licensed beds. This had the potential to affect all residents who resided in the facility. Findings included: The facility was granted a waiver of this requirement on 1/16/14. On 3/26/15, the Administrator stated the facility planned to continue to request a waiver for the number of bathing facilities and confirmed the number of five bathing facilities remained unchanged from the last annual survey.	C 422	Requested continuation of waiver	4/21/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001540	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2015
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NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF SANDPOINT	STREET ADDRESS, CITY, STATE, ZIP CODE 220 SOUTH DIVISION SANDPOINT, ID 83864
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C 422	Continued From page 2 Based on the facility license for 73 beds, the facility was required to have a minimum of at least 7 tubs/showers available for resident use.	C 422		