



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

July 9, 2015

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

Provider #: 135055

Dear Mr. Sawyer:

On **July 6, 2015**, we conducted an off-site follow-up to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **May 1, 2015**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

F328 -- S/S: D -- 42 CFR §483.25(k) -- Treatment/Care for Special Needs

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.) **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.

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 copy of the Form CMS-2567B, Post-Certification Revisit Report listing deficiencies that have been corrected is enclosed.

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Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 22, 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 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*.

As noted in the Bureau of Facility Standards' letter of **April 7, 2015**, following the survey of **March 27, 2015**, 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 **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, it will provide you with a separate formal notification of that determination.

If you believe the 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

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Street, Post Office Box 83720, Boise, Idaho, 0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

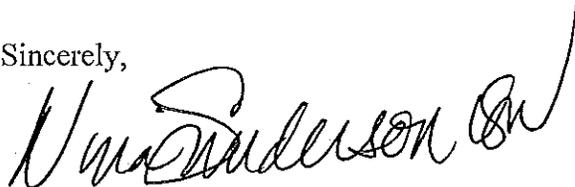
- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **July 22, 2015**. If your request for informal dispute resolution is received after **July 22, 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,



NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/dmj
Enclosures

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

PRINTED: 07/09/2015
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 R 07/06/2015
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 The following deficiency was cited during the facility's follow-up survey to the 3/27/15 recertification survey of your facility. The surveyor conducting the survey was/ Karen Marshall, MS, RD, LD 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	{F 000}	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. 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.	
{F 328} SS=D	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. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Plan of Correction paperwork and interview with the administrator, it was determined the facility failed to ensure residents with oxygen (O2) therapy received the correct physician-ordered liter flow rate. This was true for 2 of 5 residents (#s 9 & 17) reviewed for oxygen therapy. This practice created the potential to cause respiratory problems related to incorrect O2 administration and a decrease in O2 saturation levels causing residents to become anxious, confused or experience respiratory distress. Finding included:	{F 328}		

RECEIVED

JUL 23 2015

10:58 AM
7.21.15
R. Sullivan
with
administration

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

Brian V. Sawyer

TITLE

NHA

(X6) DATE

7.17.15

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 328}	<p>Continued From page 1</p> <p>The facility's Plan of Correction (POC) submitted in relation to the most recent 3/27/15 annual recertification survey was reviewed with the following results:</p> <ol style="list-style-type: none"> 1. The facility was previously cited at F328 for Resident #9. 2. Resident #9 was readmitted to the facility on 3/9/15 with multiple diagnoses including pneumonia, chronic obstructive pulmonary 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>The resident's 4/1/15 Physician Order Report contained a 3/30/15 O2 order per n/c (nasal cannula) at 1 liter per minute (LPM) for O2 saturation levels (sats) less than 88%.</p> <p>The resident's care plan, printed 3/9/15, contained the problem of potential for/actual altered breathing patterns. One of the problem interventions was O2 per nasal cannula as needed at liter flow of 1 liter per minute for O2 saturation level of less than 88%.</p> <p>Resident #9's 6/1/15 Treatment Sheet (TS) contained a 3/30/15 order for O2 that read, "O2 per n/c at 1 LPM as needed for sats less than 88%..." There was a handwritten entry under the order, "As needed O2, but sats need checked daily." The handwritten entry was not dated or initialed.</p> <p>However, the TS documented on 6/1/15 the</p>	{F 328}	<ol style="list-style-type: none"> 1. Resident number 9 was reassessed on 7/6/15 following resurvey and found to be in no respiratory distress. Her pulse oximetry was taken and noted to be 91% on oxygen per her physician's order. This information was correctly represented on her TAR. Resident number 17 discharged to home from the facility prior to resurvey so was unable to be assessed. The nurses responsible for the errors identified during resurvey were counseled on proper oxygen administration and documentation. 2. All residents with oxygen therapy orders have the potential to be affected by this issue. An audit was completed by 7/15/2015 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. This audit also included verification that oxygen saturation and liter flow rates were correctly documented on TARs. 	

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{F 328}	<p>Continued From page 2</p> <p>resident's O2 sats were determined to be "83" on "RA [room air]." The back of the TS contained a handwritten entry, dated 6/1/15 at 2130 (9:30 p.m.), "O2 83% RA - Applied 2 L [liters per minute] O2, [increased] to 92%."</p> <p>When the resident's O2 sats were 83% on RA, nursing staff administered O2 at 2 LPM not at 1 LPM as physician-ordered.</p> <p>3. Resident #17 was readmitted to the facility on 4/2/15 with multiple diagnoses including respiratory failure.</p> <p>The resident's 6/1/15 Physician Order Report contained an O2 order, "O2 at 3LPM continuous. O2 sats to be checked q [every] shift."</p> <p>The resident's care plan, printed 4/2/15, identified the problem, potential for/actual altered breathing patterns. One of the problem interventions was, "O2 @ 3L/min via nc continuous [O2 at 3 LPM by way of n/c continuous]."</p> <p>Resident #17's 6/1/15 TS contained the same 4/2/15 O2 order as was on the Physician Order Report and the care plan. The TS documented on 6/2/15 the resident's O2 sats were determined to be 95 on "RA."</p> <p>Resident #17's physician order was not followed for O2 at 3 LPM continuous.</p> <p>During a telephone interview on 7/2/15 at 1:45 p.m., the administrator was asked about the above identified residents' O2 administrations. The administrator said he look into the residents' O2 administration.</p>	{F 328}	<p>3. To ensure that this issue does not recur, a new procedure for oxygen administration and documentation was put in place requiring two LN verification of proper liter flow documentation for all residents receiving oxygen therapy. In-servicing for the new procedure and expectation of compliance for licensed nursing staff was initiated on 7/7/2015 and will be ongoing. The DNS and/or her designee will audit compliance no less than biweekly for four weeks, then no less than monthly for three months beginning 7/13/2015.</p> <p>4. To monitor ongoing compliance, The DNS and/or her designee will perform audits on all residents within the building who are receiving oxygen therapy as stated above. The DNS will report her findings to the QA committee monthly starting with August 2015 meeting. The need for ongoing monitoring and the frequency of this monitoring will be determined by the QA committee after four months.</p> <p>5. The date of correction of this issue is 7/22/2015.</p>		

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{F 328}	Continued From page 3 During a follow-up telephone interview on 7/2/15 at 4:29 p.m., the administrator said the facility was in compliance with O2 therapy as the nurses were counseled regarding Resident #9's and #17's O2 administration. The facility did not provide any additional information.	{F 328}			