



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  
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CERTIFIED MAIL: 7012 1010 0002 0836 2274

September 5, 2013

Brian V. Sawyer, Administrator  
Valley Vista Care Center of St Maries  
820 Elm Street  
St Maries, ID 83861-2119

FILE COPY

Provider #: 135075

RE: RECERTIFICATION, COMPLAINT INVESTIGATION AND STATE  
LICENSURE SURVEY REPORT COVER LETTER

Dear Mr. Sawyer:

On **August 16, 2013**, a Recertification and State Licensure survey was conducted at Valley Vista Care Center of St Maries by the Department of Health & Welfare, 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.**

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) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date, to signify when you allege that each tag will be back in compliance.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF

**CORRECTION.** After each deficiency has been answered and dated, the administrator should sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 18, 2013**. Failure to submit an acceptable PoC by **September 18, 2013**, may result in the imposition of civil monetary penalties by **October 8, 2013**.

The components of a Plan of Correction, as required by CMS include:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
  - a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.
  - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
  - c. Start date of the audits;
- Include dates when corrective action will be completed in column 5.

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.

Brian V. Sawyer, Administrator  
September 5, 2013  
Page 3 of 4

- 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*.

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 **September 20, 2013 (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 **September 20, 2013**. A change in the seriousness of the deficiencies on **September 20, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 20, 2013** includes the following:

Denial of payment for new admissions effective **November 16, 2013**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, 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 **February 16, 2014**, 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 these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; 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

Brian V. Sawyer, Administrator  
September 5, 2013  
Page 4 of 4

recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **August 16, 2013** 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 noncompliance 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:

<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 **September 18, 2013**. If your request for informal dispute resolution is received after **September 18, 2013**, 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, please contact us at (208) 334-6626.

Sincerely,



LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor  
Long Term Care

LKK/dmj  
Enclosures

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

PRINTED: 11/27/2013  
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><b>135075</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>08/16/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>VALLEY VISTA CARE CTR OF ST MARIES</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>820 ELM STREET<br/>ST MARIES, ID 83861</b>  |   |
| (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   | <p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the annual federal recertification survey of your facility. This report incorporates the changes resulting from the informal dispute resolution process (IDR) conducted on November 21, 2013.</p> <p>The surveyors conducting the survey were:<br/>Brad Perry, BSW, LSW, Team Coordinator<br/>Sherri Case, BSW, LSW, QMRP<br/>Amy Jensen, RN<br/>Becky Thomas, RN</p> <p>Survey Definitions:<br/>ADL = Activities of Daily Living<br/>BCPM = Behavior Care Program Manager<br/>BID = Twice a day<br/>BIMS = Brief Interview for Mental Status<br/>cm = Centimeters<br/>CNA = Certified Nurse Aide<br/>DON = Director of Nursing<br/>FSI = Fall Scene Investigation<br/>IPN = Interdisciplinary Progress Notes<br/>LN = Licensed Nurse<br/>MAR = Medication Administration Record<br/>MDS = Minimum Data Set assessment<br/>NIF = Non Injury Fall<br/>PO= By mouth<br/>PRN = As Needed<br/>RIR = Resident Incident Report<br/>SLP = Speech Language Pathologist<br/>TAR= Treatment Administration Record<br/>TID = Three times a day<br/>W/C = Wheel Chair</p> | F 000   | <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> |   |
| F 241<br>SS=D   | <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a</p>   | F 241   | <p style="text-align: center;"><b>RECEIVED</b><br/><b>DEC 12 2013</b><br/><b>FACILITY STANDARDS</b></p>   | 9/16/13   |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brian V. Scully TITLE: NHA (X6) DATE: 12/10/13

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 241  | <p>Continued From page 1</p> <p>manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observations and staff interview, it was determined the facility failed to maintain a resident's dignity by exposing their torso, legs, and genitals in the resident's room with the door open. This was true for 1 of 13 (#16) residents residing in the East Hallway. This created the potential for a negative effect on the resident's self-esteem. Findings included:</p> <p>1. On 8/15/13 at 5:10 PM, Resident #16 was observed in his room with the hallway door wide opened. His bed was the farthest from the doorway and he occupied the room alone. The privacy curtain closest to the doorway was partially pulled, but was opened enough to see the lower half of the resident's bed. The resident laid width-wise across his low bed with his feet on the floor closest to the window and his head occasionally resting on a blue cushioned fall mattress next to his bed. The resident was observed wearing only an incontinent brief, with the tip of his penis protruding out of the brief.</p> <p>At 5:14 PM, CNA #3 looked into the resident's room and alerted CNA #4 to come into the room. They entered his room without closing the door or drawing the privacy curtain closed. CNA #3 covered the resident's legs, genitals, and torso area with a sheet, while CNA #4 spoke to the resident. A few minutes later the aides left, leaving the resident in the room alone with the door wide opened.</p> | F 241  | <p>1. Resident #16 was afforded privacy utilizing the privacy curtain around his bed on 8/15/13. <i>9/16/13</i></p> <p>2. All residents have the potential to be affected. Through admit assessment, quarterly MDS review and prn change of status review residents will be identified for care planning needs as they relate to privacy and dignity. Dignity and privacy rounds completed by 9/4/13.</p> <p>3. In servicing held for nursing staff on privacy and dignity beginning on 9/4/13 and ongoing. Weekly QA rounds for 4 weeks and then monthly for 3 months beginning on 9/10/13.</p> <p>4. The DNS or her designee will follow this issue in QA review as stated above and report monthly to the QA committee beginning with the September QA meeting.</p> |

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| F 241   | <p>Continued From page 2</p> <p>At 5:20 PM, the resident could still be seen from the hallway in the same position as before. The sheet had been removed and the resident's incontinent brief was left unsecured from his right thigh, exposing his penis and scrotum. During this observation, two residents passed by the opened doorway on their way down the hall.</p> <p>At 5:22 PM, CNA #4 and RN #5 were in the room, with the door still opened while RN #5 spoke to the resident. RN #5's body blocked the view of the resident from the doorway.</p> <p>At 5:32 PM, the resident's doorway was still opened, but the privacy curtain closest to the door was closed enough so the resident could not be seen from the hallway.</p> <p>On 5/15/13 at 5:30 PM, CNA #4 was interviewed regarding the incident and was asked why the door was not closed after discovering the resident in the condition he was found, she stated, "There's no answer for that."</p> <p>On 5/15/13 at 5:35 PM, RN #5 was interviewed regarding the incident and he stated, "I assumed he [the resident] could not be seen."</p> <p>On 8/15/13 at 6:40 PM the Administrator, Administrator in Waiting, DON, Corporate Nurse, Resident Services, and Behavior Care Manager were informed of the issue. No further information was provided.</p> | F 241  |   |   |
| F 280<br>SS=D   | <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged</p>   | F 280  |   | 9/16/13   |

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| F 280  | <p>Continued From page 3</p> <p>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.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, record review, and staff interview, it was determined the facility failed to update resident care plans in a timely manner after changes in the residents' status occurred. This was found to be true for 3 of 9 (#s 2, 5 &amp; 6) sampled residents. 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>1. Resident #2 was admitted 8/04/06 with diagnoses which included Huntington's Chorea, dementia, depression, pain and expressive aphasia (loss of ability to talk).</p> <p>Review of Resident #2's most recent quarterly</p> | F 280  | <p>1. Resident #2 had adjustments made in her chart care plan by 9/16/13 to reflect the changes of honey thick liquids and head stabilization during meals. Resident #5 had changes done to his care plan by 9/4/13 to reflect the discontinuation of regular psychiatrist reviews and weekly behavioral program manager reviews. Resident #6 had his care plan adjusted by 9/4/13 to reflect increased head of the bed for thirty minutes following meals.</p> <p>2. All residents have the potential to be affected. Through admit assessment, quarterly MDS review and prn change of status review residents will be identified for care planning updates.</p> <p>3. In servicing done for nursing staff on assessment and care planning beginning on 9/4/13 and ongoing. Weekly QA rounds for 4 weeks and then monthly for 3 months beginning on 9/10/13</p> |                      |  |

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| F 280  | <p>Continued From page 4</p> <p>MDS assessment, dated 5/24/13, documented the resident required total assistance of 1 staff for eating.</p> <p>a. Resident #2's Care Plan for Alteration in Nutritional/Fluid intake, dated 5/30/13, documented Resident #2 was to have nectar thick liquids. The undated ADL Care Plan for eating documented the resident was to have nectar liquid via a nose cup (cup with special cut out).</p> <p>During a morning meal observation, on 8/13/13 at approximately 9:00 a.m., CNA #1 was observed to be sitting in a chair using a nose cup to assist the resident to eat. The contents of the cup were documented to be the consistency of honey. CNA #1 was asked about the consistency in the cups and stated liquids were to be honey thick.</p> <p>On 8/15/13 at 11:50 a.m. the Rehabilitation Director (RD) provided a Interdisciplinary Progress Note from the Speech Language Pathologist (SLP) , dated 6/21/13 that stated "increased difficulty with nectar liquids...honey liquids." The RD stated the care plan should have been revised to state honey thick liquids.</p> <p>b. Resident #2's Care Plan did not include that staff were to stabilize her head, when assisting her to eat, by placing their hand on top of her head.</p> <p>During a morning meal observation, on 8/13/13 at approximately 9:00 a.m., CNA #1 was observed to be sitting in a chair to the resident's left side.<br/>Resident #2 was documented to move her head</p> | F 280  | 4. The DNS or her designee will follow this issue in QA review as stated above and report monthly to the QA committee. |                      |

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| F 280   | <p>Continued From page 5<br/>up, down and left and right while being assisted to eat.</p> <p>On 8/16/13 at 9:15 a.m. the SLP stated when the resident was moving her head staff assisting her to eat should stabilize her head by placing their hand on top of her head.</p> <p>2. Resident #6 was readmitted to the facility on 11/8/11 with multiple diagnoses, which included degenerative arthritis, paraplegia, chronic pain, dementia, congestive heart failure, hypertension and chronic obstructive pulmonary disease.</p> <p>Resident #6's ADL Care Plan, in the Diet section, documented the resident was at high aspiration risk and included an intervention to have the HOB (head of bed) elevated greater than 30 degrees for meals and for 30 minutes after meals. The care plan in the medical record for nutrition did not include the HOB was to be at 30 degrees after meals and documented the resident was to be upright for at least 20 minutes after eating. The ADL Care Plan was not consistent with the current care plan in the medical record.</p> <p>On 8/16/13 at 8:30 a.m. the Corporate Nurse stated the ADL Care Plan was used by the CNA to provide care and was part of the resident's permanenet record.</p> <p>3. Resident #5 was admitted to the facility on 3/26/07 with multiple diagnoses including dementia, hypertension, psychosis, delusions - paranoid, hallucinations and depression.</p> <p>a. Resident #5's Care Plan for the problem of Risperdal use related to psychosis documented the resident was to have regular consultation with</p> | F 280  |   |   |

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| F 280   | Continued From page 6<br>a psychiatrist for changes/review.<br><br>On 8/14/13 at 1:53 PM, the DON was interviewed and asked how often regular consultations took place. The DON stated Resident #5 had previously been on their behavioral unit would get a quarterly review. However, Resident #5 no longer resided on the behavioral unit. The DON stated the care plan should have been revised.<br><br>b. Resident #5's care plan documented the resident was to have weekly reviews by the behavior program manager with direct care staff for efficacy of current non medication interventions and for changes needed, "when clinically indicated."<br><br>On 8/14/13 at 2:15 PM, the Behavior Care RN was interviewed and asked if Resident #5 was getting weekly reviews by the behavior program manager. The Behavior Care RN stated, "no, the resident does not get weekly reviews by the behavior program manager and that should come off the care plan." | F 280   |   |   |
| F 309<br>SS=D   | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced  | F 309   | 1. Resident #10 was assessed on 8/13/13 for psychological harm with none noted. Immediate in services were held. Resident #2 had care plan adjustments made by 9/4/13 per ST recommendations. | 9/16/13   |

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

PRINTED: 11/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                              |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>135075</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>08/16/2013</b> |
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| F 309   | <p>Continued From page 7</p> <p>by:<br/>Based on observation, record review, and staff interview it was determined the facility failed to ensure each resident received care and services to maintain their highest level of functioning. This was true for 2 of 13 sampled residents (#s 2 &amp; 10). The facility's failure to provide appropriate care to residents with dementia placed Resident #10 at risk for psychosocial harm. Resident #2 had the potential for more than minimal harm if she choked on her meals and aspirated.</p> <p>1. Resident #10 was admitted to the facility on 9/10/12 with multiple diagnoses to include dementia with behavioral disturbance, psychosis, anxiety, depression, and pain.</p> <p>The Resident's Significant change MDS dated 7/30/13, coded the following:<br/>*Sometimes has the ability to understand others and make self understood,<br/>*Inattention and disorganized thinking - behavior consistent over time,<br/>*Cognition is severely impaired,<br/>* Physical behavioral symptoms directed towards others, occurred 4-6 days, but less than daily,<br/>*Verbal behavioral symptoms directed towards others, occurred daily,<br/>*Somewhat important to choose between a tub bath, shower, bed bath, or sponge bath,<br/>*Very important to be able to use the phone in private,<br/>*Extensive assist of two people for personal hygiene,<br/>*Total assist of two people for bathing.</p> <p>NOTE: The only dates documented on each of the care plans were the "Origin dates" which indicated the original date the "Problem was</p> | F 309   | <p>2. All residents have the potential to be affected. Through admit assessment, quarterly MDS review and prn change of status review residents will be identified for behavioral management and care planning updates.</p> <p>3. In servicing done for nursing staff on behavioral management and care planning updates beginning on 9/4/13 and ongoing.<br/>Weekly QA rounds for 4 weeks and then monthly for 3 months beginning on 9/10/13.</p> <p>4. The DNS or her designees will follow this issue in QA review as stated above and report monthly to the QA committee beginning with the September QA meeting.</p> |                      |   |

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

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| F 309   | <p>Continued From page 8</p> <p>identified and the "Estimated Date" which indicated the date the identified goal should be met. It could not be determined when the Care Plan Focus Area and Intervention areas were reviewed or revised.</p> <p>Resident #10's Care Plan documented the following:</p> <p>Problem #7 dated 9/14/12, Alternate Thought Process/Cognition Loss/Communication documented the following interventions:</p> <ul style="list-style-type: none"> <li>- Give simple step by step directions, face resident and speak clearly, explain care before doing.</li> <li>- Develop a routine and minimize confusion and avoid surprises.</li> <li>- Introduce one idea at a time; Keep it simple.</li> <li>- Do not offer multiple choices.</li> <li>- Distract the person if they become angry or agitated.</li> </ul> <p>Problem #8, dated 9/13/12, Mood/Behavioral Alteration documented the following interventions:</p> <ul style="list-style-type: none"> <li>- Explain care prior to care given. Allow resident time to process information.</li> <li>- Give resident choices that will produce desired result.</li> <li>- Change staff as needed for increased behaviors or anxiety. Give space from a safe distance...</li> </ul> <p>Problem #16, Potential for Diversional Activity Deficit/ Psychosocial Well-Being dated 9/19/12...documented the following interventions:</p> <ul style="list-style-type: none"> <li>- "Resident states the following are very important: choosing what clothes to wear, taking care of personal belongings, choosing own bed time and being able to use the phone in private."</li> <li>- "Resident states it is somewhat important to choose own bathing preference; assist as needed."</li> </ul> | F 309  |   |   |

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

PRINTED: 11/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |   |                      |
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| F 309  | <p>Continued From page 9</p> <p>Resident #9's Care plan documented conflicting interventions. The Alternate Thought Process/Cognition Loss/Communication care plan documented, "Do not offer multiple choices. The Mood/Behavioral Alteration care plan documented, "Give resident choices that will produce desired results."</p> <p>On 8/13/13 the following was observed:<br/>-10:15 a.m., on the BCP unit Resident #10 was sitting in her wheel chair in the common area. The resident with a raised voice said, "Give me the phone, give me that damn phone! It's my boyfriend not yours," and began pounding on the arm of the recliner she was sitting next to. Bath Aid #6 came to the common area where Resident #10 was sitting and began to wheel her to her room.</p> <p>Resident #10's Alternate Thought Process/Cognition Loss/Communication Care Plan documented, "Give simple step by step directions, face resident and speak clearly, explain care before doing." Bath Aide #6 did not explain to Resident #10 what she was doing prior to escorting back to her room, nor did she address or validate the Resident's concerns about wanting a phone. The resident's MDS and Care Plan documented using the phone was very important to the resident.</p> <p>-10:18 a.m. Resident #10 was then observed near her room, in her wheel chair, with her feet placed firmly on the ground. Bath Aide #6, Bath Aide #7, and RN #8 had surrounded the resident's wheel chair. Resident #10 stated, " No I don't want to go to my room, I want to talk to [Husband's name], get me a phone."</p> | F 309  |   |                      |

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

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FORM APPROVED  
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| F 309   | <p>Continued From page 10</p> <p>The resident repeated several times that she didn't want to go to her room she wanted a phone so she could talk to her husband. At no time did RN #8, Bath Aide #6, or Bath Aide #7 address Resident #10's request for a phone or validate her need to speak with her husband.</p> <p>-10:20 a.m. The surveyor observed a scratch to the underside of RN #8 left wrist. The surveyor asked the RN how she got the scratch. The RN stated, " [Resident #10's name], that is just how she is." The surveyor asked the RN if the scratch just happened and the RN responded, "Yes" and left the BCP unit.</p> <p>-10:30 a.m. Bath Aide #6 wheeled Resident #10 into her room and the resident placed her feet firmly on the floor. Bath Aide #6 asked the resident if she could take her into the bathroom and then give her a bed bath. Resident #10 said, "No, get me a phone I need to call my husband [husband's name]." The resident then picked up a clean incontinent brief off of the end of her bed, opened it up and began to talk into it. The surveyor asked Bath Aide #6 why the resident could not have a phone. Bath Aide #6 said, "If we gave into [Resident's name] every time she wanted the phone we would never get anything done. I have 30 other residents to shower today."</p> <p>-10:35 a.m. Bath Aide #6 asked the Resident if she wanted a washcloth to wash her face, and the resident responded, "No I don't want a damn washcloth." Resident #10 began to cry and said, "I'm on the phone with my husband, he is so sick." Bath Aide #7 said to the resident, "We can send someone over to look after [husband's name]." Resident #10 responded with, "I don't</p> | F 309  |   |   |

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

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FORM APPROVED  
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| F 309   | <p>Continued From page 11</p> <p>want anyone going over to take care of him. I just want to go home."</p> <p>After Resident #10 began to cry and express concern about her husband neither one of the bath aides attempted to validate Resident #10's concerns about her husband being sick or try to identify the root cause of her feelings of agitation and anxiety. The surveyor asked Bath Aide #6 at what point did the staff step back, reassess the situation walk away, re-approach later and/or get Social Services involved. Bath Aide #6 said, "I have behavior training and I know how to handle the situation."</p> <p>-10:40 a.m. Bath Aide #6 stood in front and over Resident #10 and asked, "What's wrong?" Resident #10 responded, "Everyone is bothering me too much. I'm ready to kill everybody. You know how I get." Bath Aide #6 did not respond to Resident #10's statements. Bath Aide #6 then asked Resident #10 if she would let her [Bath Aide #6], "at least wipe her face off before she took her out of her room because she couldn't go out where everyone else was with a dirty face."</p> <p>-10:45 a.m. Resident #10 still had the clean incontinent brief in her hand and Bath Aide #6 asked the resident if the resident would "trade her the incontinent brief for the telephone." Resident #10 responded with, "If you would just shut your mouth and leave me alone." Bath Aide #6 then asked the resident, "How are you today?" The resident continued to tell Bath Aide #6 to leave her alone. Bath Aide #7 left the room to find another staff member to help. Bath Aide #7 returned to Resident #10's room with CNA #3.</p> <p>-10:50 a.m. Bath Aide #6 told Resident #10 she</p> | F 309   |   |                      |   |

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

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FORM APPROVED  
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| F 309   | <p>Continued From page 12</p> <p>[Bath Aide #6] needed to move Resident #10 from out of her room so Resident #10's roommate could get out of the room. Resident #10 said, [Resident #8] could leave the room if she wanted to." Bath Aide #7 told Resident #10 that Resident #8 could not get around her and she [Resident #10] would have to move so Resident #8 could get out. Bath Aide #6 started to move Resident #10's wheelchair backwards. Resident #10 grabbed Bath Aide #6 by the wrist and told the bath aide, "Get your damn hands off of me."</p> <p>Resident #10's care plan documented, introduce one idea at a time and keep it simple and allow resident time to process the information. The Bath Aides had introduced going into her room, toileting, bed bath, washing her face, and leaving her room all within 20-25 minutes.</p> <p>-10:55 a.m. RN #8 told the Bath Aids that she could give Resident #10 a Klonopin if it was needed to get Resident #10 to take a bath. The surveyor asked the RN if she routinely gave Resident #10 Klonopin to get her to take a bath. RN #8 said, "Some days I end up giving Resident #10 Klonopin, Morphine, and Ativan." RN #8 also told the surveyor, "I gave [Resident #10's name] some Morphine just a little while ago and the morphine usually takes care of [Resident #10's name] intensifying behaviors."</p> <p>-4:30 p.m. The surveyors notified and interviewed the DNS, BCPM, Resident Service Coordinator about the above observation. The surveyors asked the BCPM what staff has been trained to do when a resident refuses care. The BCPM said, "Back off and give them space." The surveyors asked her to define space and how long do you</p> | F 309  |   |   |

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

PRINTED: 11/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

|   |   |  |   |
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| F 309              | <p>Continued From page 13</p> <p>give them space. The BCPM said, "As much space as they need and/or take the resident to another area if need be. We train staff to give space for at least 15-30 minutes." The surveyors asked if staff should take a resident whose agitation had escalated to his/her room if the roommate is present in the room. The BCPM said, "No." The surveyors asked if residents are allowed to make phone calls. The BCPM said residents are allowed to make phone calls with staff assistance. The BCPM was asked if Resident #10's husband had requested that Resident #10 not be allowed to make phone calls to him. The BCPM said, "[Resident #10's husband] has never said that Resident #10 should not call him."</p> <p>The surveyors asked what staff does if a resident is focused on a specific event in time and/or death/sickness of a spouse or loved one. The BCPM said the facility has been training staff over the last 6 months using the "Join their journey" training module. She also said, "We have always promoted being in the moment with the resident."</p> <p>The surveyors asked how staff knew what to do when a resident refused to bathe. The BCPM said the resident has the right to refuse and staff should not force the resident, "No means no." The BCPM was asked if the above observation should have happened. She said it should not have happened and staff has watched the video, "Bathing Without a Battle."</p> <p>The surveyors asked if it was appropriate to distract the resident if the resident was focused on a person, place or event. The BCPM said, No the staff needs to be where the Resident is and validate what the resident is focused on. The</p> | F 309         |   |                      |

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

PRINTED: 11/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

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| F 309 | <p>Continued From page 14</p> <p>surveyors asked if it was appropriate to distract a resident if the resident was focused on a person, or if it was appropriate if staff should attempt to redirect the resident. The BCPM said, No the staff needs to be where the resident is and validate what the resident is focused on. The resident's care plan stated, "Distract the person if they become angry or agitated."</p> <p>The surveyors asked the DNS if the facility had an LSW. The DNS said the facility has a consulting LSW that comes to the facility twice a year from out of state, approximately every six months. The surveyors asked what the facility does in the event the LSW is needed to assist with acute/chronic psychosocial issues between the consultant's scheduled visits. The DNS said the facility could email the consultant regarding the issue or they would call the psychiatrist. The facility did not provide evidence that the LSW was consulted regarding Resident #10's escalating agitation that resulted in the ongoing administration of PRN medication. Refer to F329 for additional details.</p> <p>On 8/14/13 at 8:00 a.m., the surveyor reviewed Resident #10's medical record, specifically the nurse's notes for documentation related to the incident that occurred on 8/13/13. There was no documentation to indicate the incident observed by the surveyor had ever taken place on 8/13/13. The surveyor asked the BCPM at 9:00 a.m. where to look in the resident's chart for the above information. The BCPM said she had looked in the resident's chart on 8/13/13 after she met with the surveyors and there was nothing documented about the incident by nursing staff or the resident service coordinator (social service staff). The surveyor asked the BCPM if the nursing staff</p> | F 309 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 309 | <p>Continued From page 15</p> <p>should have provided documentation related to the incident. She said, "yes, it should have been documented in the Interdisciplinary Progress Notes."</p> <p>On 8/14/13 at 2:25 p.m. Bath Aide #7 was interviewed, with the Administrator, DNS, Human Resources, and the BCPM present, related to the incident on 8/13/13. Bath Aide #7 said, "The situation should have never occurred. I realized that we should have stopped when she [Resident #10] put her feet down and come back later."</p> <p>On 8/14/13 at 2:55 p.m. RN #8 was interviewed related to the incident on 8/13/13. RN #8 said, "I was walking by the room [Resident #10's] room and asked Bath Aide #6 if I needed to give Resident #10 a Klonopin. I knew she [Resident #10] was giving them [Bath Aides] trouble about the bath. I thought the Klonopin would make her more receptive to having a bath. I did not redirect the staff to leave Resident #10 alone. Resident #10 is obsessed with calling husband [husband's name]."</p> <p>The facility failed to ensure appropriate staff interactions with a resident who had severely impaired cognitive skills. The facility did not appropriately identify and validate the resident's concerns; allow her to exercise her right to refuse a bath; or allow her to make a private telephone call to her husband. Further, the facility nurse offered to medicate the resident for the refusal of care and increased agitation.</p> <p>2. Resident #2 was admitted 8/04/06 with diagnoses which included Huntington's Chorea, dementia, depression, pain and expressive aphasia (inability to talk).</p> | F 309 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/27/2013  
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><b>135075</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>08/16/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>VALLEY VISTA CARE CTR OF ST MARIES</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>820 ELM STREET<br/>ST MARIES, ID 83861</b>                          |                      |   |
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F 309

Continued From page 16  
Review of Resident #2's most recent quarterly MDS assessment, dated 5/24/13, documented the resident required total assistance of 1 staff for eating.

Resident #2's Care Plan for Alteration in Nutritional/Fluid intake, dated 5/30/13, included an intervention (#29) "Resident's chair to (sic) tall for staff to sit and feed, staff to stand and feed due to chair height."

During a morning meal observation, on 8/13/13 at approximately 9:00 a.m., CNA #1 was observed to be sitting in a chair, to the resident's left side, using a nosey cup (cup with special cut out) to assist the resident to eat. Resident #2 was observed to cough and move her head up, down and left and right while being assisted to eat. At 9:28 a.m. the Behavior Care Manager was observed to stand and give Resident #2 a few bites of food.

On 8/15/13 at 10:30 a.m. the Rehabilitation Director stated he had called the Speech Language Pathologist (SLP). The SLP had told him staff were to stand to assist the resident to eat as the resident will look down at staff who are sitting "which can cause aspiration." The Rehabilitation Director stated that if the resident elevates her chin it "opens her airway."

On 8/16/13 at 8:30 a.m. the Corporate Nurse (CN) and the DON provided a copy of Resident #2's "ADL Care Plan." The Eating section of the care plan included (#12) "may stand while feeding due to movement." The CN stated the ADL care plan was part of the resident's permanent record and was what the CNAs use to direct care of the resident. The CN stated the ADL Care Plan did

F 309

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

PRINTED: 11/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                              |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>135075</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>08/16/2013</b> |
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| F 309   | Continued From page 17<br>not say staff were required to stand. The CN stated the speech therapist was unable to find documentation staff needed to stand due to Resident #2 choking. The CN also provided a copy of Resident #2's 4/5/11 nutrition care plan. The care plan included a hand written statement (#32), dated 4/5/11, "Staff to stand & feed due to chair height is to (sic) tall to sit & feed."<br><br>An 11/21/11 Dietary report documented, "staff stand to feed due to chair to (sic) high."<br><br>On 8/16/13 at 9:15 a.m. the SLP stated the CNAs needed to assess the resident each time the resident was eating to determine if they (CNA) should stand or sit to assist the resident to eat. The SLP stated he makes recommendations and writes them down and they are tagged in the chart. The SLP stated he never sees the actual care plan or flow sheets (used by the CNAs for care) for the residents, but speaks with the RN and CNAs. The SLP stated he recommended standing to assist Resident #2 to eat due to the height of the chair. The SLP was shown the Alteration in Nutrition Care Plan documenting staff were to stand and feed due to the height of the chair. The SLP stated he must have written it down if it was in the original care plan. | F 309   |   |                      |   |
| F 314<br>SS=G   | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>Based on the comprehensive assessment of a  | F 314   |   | 9/16/13              |   |

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

PRINTED: 11/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

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|--------------------|--|---------------|--|----------------------|
| F 314              | <p>Continued From page 18</p> <p>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.</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 ensure residents who entered the facility without pressure sores did not develop pressure sores. This was true for 2 of 4 (#1 &amp; #12) sampled residents reviewed for pressure sores. The facility failed to assess and prevent a stage III pressure ulcer from forming on Resident #1's coccyx, causing harm and put the resident at risk for pain and infection. The facility also failed to prevent a stage II pressure ulcer to Resident #12's sacrum. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 5/3/13 with multiple diagnoses including left hip fracture, deep wound infection, chronic pain, and urinary tract infection.</p> <p>Resident #1's admission MDS dated 5/10/13, coded:<br/>* did not have pressure sores,<br/>* had Moisture Associated Skin Damage (MASD),<br/>* required two person assist with bed mobility,<br/>* frequently incontinent of bladder and bowel,<br/>* moderately cognitively impaired.</p> <p>The Resident's Interdisciplinary Progress Notes</p> | F 314         | <p>1. Resident #1's wound was resolved on 7/27/13. Resident #12 was seen by NP Wound Nurse on 8/16/13 and had care plan adjustments made. <i>9/16/13</i></p> <p>2. All residents have the potential to be affected. Through assessment using the Braden Scale on admit, quarterly and prn change residents at risk will be identified. Skin review completed by Wound and Skin nurse by 9/6/13.</p> <p>3. In servicing done for nursing staff on wound and skin care prevention and treatment beginning on 9/4/13 and ongoing. Referrals made to NP Wound and Skin Nurse. Weekly QA rounds for 4 weeks and then monthly for 3 months beginning on 9/10/13. Patient at Risk Committee will review pressure Ulcers weekly beginning on 9/10/13. Barrier cream adjustment made to use of Clear unless being treated for MASD/IAD.</p> <p>4. The DNS or her designee will follow this issue in QA review as stated above and report monthly to the QA committee beginning with the September QA meeting.</p> |                      |

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

PRINTED: 11/27/2013  
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><b>135075</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                   | (X3) DATE SURVEY COMPLETED<br><br><b>08/16/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>VALLEY VISTA CARE CTR OF ST MARIES</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>820 ELM STREET<br/>ST MARIES, ID 83861</b> |   |

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|--------------------|---|---------------|---|----------------------|
| F 314              | <p>Continued From page 19</p> <p>dated 5/20/13 by an LN documented, "C.N.A. called me to res[ident] room to observe an open sore to sacrum. This sore is 1.5 cm x (by) 1.5 cm x 4 mill[imeter]." An LN note on 5/21/13, documented, "Stage II pressure ulcer observed @ [at] coccyx, approx[imately] dime size open lesion. Skin surrounding site [with] blanching redness, new foam dressing applied [with] Cavilon @ wound edges, resident tolerated procedure well, two person max[imum] assist [with] repositioning and bed to chair transfers. Continue to monitor." Note: There were no progress notes for five days prior to 5/20/13, when the pressure sore was discovered.</p> <p>The Resident's Wound Care Flow Sheet, documented in part the following:<br/>"Site #2 Acquired here,<br/>5/22/13-P.U. [pressure ulcer] Stage III, coccyx, .9 x 1 cm x .4 cm, color- pink, tissue-80/20% slough/pink, pain-0,<br/>5/29/13-.8 x .8 x .2 cm, 100% covered [with] tan slough,<br/>6/7/13-.8 x .4 x .2 cm, 50% pink/50% tan slough,<br/>6/14/13-.5 x .5 x .2 cm, 100% pink, granulation,<br/>6/21/13-.5 x .5 x .1 cm, pink,<br/>7/10/13-.3 x .3 x .1 cm, pink,<br/>7/15/13-Resolving Stage III, .2 x .2 x .1 cm, pink,<br/>7/22/13-.1 x .1 x .1 cm, pink,<br/>7/24/13-Resolved."</p> <p>The Resident's Pressure Sores/Skin Care plan dated 5/3/13, documented:<br/>"Treat as high risk,<br/>Turn every 2 hours and PRN side-side,<br/>Float heels,<br/>Alt[ernating] air mattress,<br/>Calazime or Calmoseptine to inner buttocks as needed,</p> | F 314         |   |                      |

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

PRINTED: 11/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                              |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>135075</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>08/16/2013</b> |
|---|---|---|---|----------------------|---|
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| F 314   | <p>Continued From page 20<br/>Liner open as tolerated."</p> <p>The Resident's High Risk Pressure Relief Interventions (ADL Care Plan) dated 5/8/13, documented:<br/>"Pressure relief cushion in chair/wheelchair or geri chair,<br/>Barrier cream with each incontinent episode,<br/>Use Calmoseptine/Calazime to the buttocks MASD."</p> <p>The Resident's May 2013 TAR documented on 5/5/13, "Bilat[eral] R [right] buttock-cleaner [with] pericare apply Calmoseptine prn &amp; BID." The TAR also contained four out of six opportunities when Calmoseptine should have been applied but was not documented as being applied between 5/16/13 to 5/18/13.</p> <p>The Resident's Physician's Telephone Orders dated 5/28/13, documented, "Pressure ulcer to coccyx-Stage III, 1) Vit[amin] C 250 mg PO daily until resolved, 2) Zinc 220 mg PO daily x 30 days, 3) Santyl Collagenase to wound bed daily until 0 [no] slough present."</p> <p>On 8/14/13 at 11:45 AM, the Wound Nurse was interviewed regarding Resident #1's Stage III pressure ulcer and she stated the pressure ulcer went from, "nothing to a III." When asked how this happened she stated, "I don't know that...I have just as much questions [sic] about that." She said she had interviewed C.N.A. and nursing staff on how the ulcer went from red to open, but said they did not have the answers either. She stated, "did the Calmoseptine get down to skin?" When asked to clarify this statement, she said she questioned if the pericare was adequate enough in order for the the barrier cream to be</p> | F 314   |   |                      |   |

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

PRINTED: 11/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |   |
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| F 314 | <p>Continued From page 21 effective. Note: The resident was incontinent of bowel and bladder and the Calmoseptine was in place to treat excoriation due to MASD and to prevent pressure ulcers.</p> <p>On 8/15/13 at 6:40 PM the Administrator, Administrator in Waiting, DON, Corporate Nurse, Resident Services, and Behavior Care Manager were informed of the issue.</p> <p>On 8/19/13 the facility faxed additional information regarding Resident #1's situation. The additional information contained the following statement, "At the time the pressure ulcer was discovered to the coccyx, she was being treated for MASD which was present on admit. The bilateral buttocks were excoriated with erosion secondary to incontinence of bowel and bladder; the treatment was Calmoseptine ointment, which is a thick pink ointment. It was to be applied in a thin layer after each incontinent episode. This may have contributed to not visualizing the affected tissue turning red prior to opening."</p> <p>The facility failed to prevent a Stage III pressure sore due to failing to assess and differentiate between red skin and pink barrier cream, causing harm to the resident.</p> <p>2. Resident #12 was admitted to the facility on 3/18/08 with multiple diagnoses including Alzheimer's disease, dementia, paranoid delusions, psychosis, and anxiety.</p> <p>Resident #12's quarterly MDS dated 4/12/13, coded:<br/>           * did not have pressure sores,<br/>           * required one person assist with bed mobility,<br/>           * frequently incontinent of bladder and bowel,</p> | F 314 |  |  |
|-------|---|-------|--|--|

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

PRINTED: 11/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |   |
|--|---|--|---|
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| F 314 | <p>Continued From page 22<br/>* severely cognitively impaired.</p> <p>The Resident's Interdisciplinary Progress Notes, documented on 7/23/13, "Stage II P.U. found to sacrum-dres[sin]g of Exuderm thin placed...PUCP [pressure ulcer care plan] initiated...Braden scale =#16=@ risk-will tx [treat] as High. ADL CP updated to get oob [out of bed] for meals only, side lying position [with] Q [every] 1-2 [hour] turning. Plus 2 TID [with] med pass for added protein to aid in wound healing. Risk factors include: B&amp;B [bowel and bladder] incontinence, freq[ue]nt resistance to cares, psychosis, Alz[heimer's] dementia, delusions, aggressions, DM [diabetic mellitus]."</p> <p>The Interdisciplinary Progress Notes document in part the following:<br/>"7/25/13-Wound bed pink, dry. Edges clean. Surrounding tissue intact, blanching,<br/>7/26/13-Tissue surrounding wound pink &amp; blanches,<br/>7/27/13-Surrounding tissue pink &amp; blanches."<br/>Note: Similar notes as above are found on 7/28, 7/29, 7/30, 7/31, 8/1, 8/2, 8/3, and 8/4/13.<br/>The resident was sent to a local hospital on 8/5/13 for two days for an unrelated non-responsive incident.<br/>"8/7/13-P.U. to sacrum-now unstageable [secondary to] 95% covered [with] grey/black moist tissue, red bleeding tissue pinpoint in center. Surrounding tissue is irritated, red dry, and blanching-appears to be from old drsg [dressing]. Wound bed cleaned, new thin hydrocolloid placed. Will obtain order for Collegen gel to debrided necrotic tissue...Continue to tx as High,<br/>8/8/13-Surrounding tissue red, dry. Cavilon skin prep to edges &amp; surrounding tissue, Collagen</p> | F 314 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |   |
|--|---|--|---|
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|---|--|

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|--------------------|--|---------------|---|----------------------|
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| F 314 | <p>Continued From page 23</p> <p>hydrogel placed on necrotic tissue for debrided. Covered [with] adhesive foam. Added to PUCP to be last up &amp; first down-up for meals only-as tolerated,</p> <p>8/12/13-P.U. to sacrum originally found as Stage II-while @ [local hospital] P.U. worsened and upon return the wound bed was covered [with] grey/black moist eschar = unstageable. Tx of Collagen gel to debride successful as [no] eschar present today. Wound bed 100% pink, moist [with no] maceration to edges. Surrounding tissue [with] some blanching redness."</p> <p>The Resident's Wound Care Flow Sheet, documented in part:<br/>"7/23/13-Stage II, L[ength] .8 W[idth] .5 D[epth] .2 [cm],<br/>8/5/13-Resident @ [local hospital],<br/>8/12/13-Stage III, L 1.8 W .7 D .2 [cm]."</p> <p>The Resident's Potential for Pressure Ulcer, Impairment of Skin Integrity Care Plan dated 11/16/12, documented in part the following interventions:<br/>*Pressure relief mattress,<br/>*Observe for any skin impairment with giving care,<br/>*Gel cushion in W/C.</p> <p>The Resident's Potential for Pressure Ulcer, Impairment of Skin Integrity Care Plan dated 7/25/13, documented in part the following additional interventions:<br/>*Pressure reducing Gel cushion in W/C,<br/>*Turn q 1-2 [hours] side to side. Use pillow behind back for side lying position.</p> <p>The Resident's Physician's Telephone Orders dated 7/23/13, documented, "Exuderm</p> | F 314 |  |  |
|-------|---|-------|--|--|

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

PRINTED: 11/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

|   |   |   |  |                      |   |
|---|---|---|--|----------------------|---|
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| F 314   | Continued From page 24<br>thin-Hydrocolloid drsg to P.U. on sacrum. [Check every] 3 days & PRN. K2 Plus [supplement] TID [with] med pass 90-120 cc-aid in wound healing."<br><br>On 8/15/13 at 12:15 PM, the Wound Nurse was interviewed regarding Resident #12's Stage II pressure sore. When asked how the resident acquired the sore, she stated, "I don't know...She was low risk...It's a never event." When asked to clarify what she meant by a 'never event', she stated, "It should not have happened."<br><br>On 8/15/13 at 6:40 PM the Administrator, Administrator in Waiting, DON, Corporate Nurse, Resident Services, and Behavior Care Manager were informed of the issue.<br><br>On 8/19/13 the facility faxed additional information regarding Resident #12's situation. The additional information contained the following statement, "She is often combative during and resistant to cares."<br><br>The resident's Care Plan did not contain a section which identified the resident displayed resistance to cares. The Resident's Interdisciplinary Progress Notes from 7/11/13 to 7/23/13 and Social Services Progress notes 4/20/13 to 7/23/13 did not mention resistance to cares or interventions tried. Resident #12's Psychopharmacologic Behavior Monitor Sheet under the section entitled, "Refuses position changes" from 7/1/13 to 7/23/13, documented the resident had no refusals for the AM shift, two refusals for the PM shift, and three refusals during the night shift. | F 314   |  |                      |   |
| F 315<br>SS=D   | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER   | F 315   | 1. Resident #3 MD notified and approved a Urological consult on 9/3/13, care plan adjusted for toileting needs on 8/16/13. | 9/16/13              |   |

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

PRINTED: 11/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>135075  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____           | (X3) DATE SURVEY COMPLETED<br><br>08/16/2013  |                      |
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| F 315  | <p>Continued From page 25</p> <p>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 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 record review, Policy/Procedure review, and staff interview it was determined the facility failed to ensure a resident who had recurrent UTI's received additional evaluation to rule out causative factors such as structural abnormalities, medical conditions, or medication use. This was true for 1 of 9 (#3) sampled residents. This failed practice placed the resident at risk for decreased continence, skin breakdown and pain.</p> <p>Resident #3 was admitted to the facility on 6/3/2011 with multiple diagnoses to include, Alzheimer's disease, rheumatoid arthritis, levoscoliosis, kyphosis, and compression fracture at T10 (thoracic vertebrae). Levoscoliosis is the bend of the spine situated in the person's lower back and, once it reaches the pelvic area and a little over it, it starts to bend abnormally. This abnormal bend can lead to difficulty urinating and kidney failure.<br/>Kyphosis = "C"-shaped curve in the spine.</p> <p>The Resident's Quarterly MDS dated 5/31/13,</p> | F 315  | <p>2. All residents have the potential to be affected. Through admit assessment, quarterly Restorative Nursing review, prn change of status review and through daily rounds residents with incontinence issues, signs and symptoms of UTIs will be identified for proper treatment and care planning for toileting needs.</p> <p>3. In servicing done for nursing staff on assessment and follow up regarding incontinence management and UTI's beginning on 9/4/13 and ongoing. Weekly QA rounds for 4 weeks and then monthly for 3 months beginning on 9/10/13.</p> <p>4. The DNS or her designee will follow this issue in QA review as stated above and report monthly to the QA committee beginning with the September QA meeting.</p> |                      |

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

PRINTED: 11/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

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| F 315 | <p>Continued From page 26 coded in part the following;</p> <ul style="list-style-type: none"> <li>- Makes self-understood and has the ability to understand others - sometimes,</li> <li>- Cognition severely impaired,</li> <li>- Extensive assist of one person for toileting, personal hygiene, and bathing,</li> <li>- [Resident is on a] Urinary Toileting Program with decreased wetness,</li> <li>- Frequently incontinent.</li> </ul> <p>Note: The only dates documented on each of the following care plans were the "Origin dates" which indicated the original date the "Problem was identified and the "Estimated Date" which indicated the date the identified goal should be met. It could not be determined when the Care Plan Focus Area and Intervention areas were reviewed or revised.</p> <p>Resident #3's Care Plan documented the following:<br/>*Problem #8 dated 6/8/11, Urinary/Bowel Incontinence documented the following interventions:</p> <ul style="list-style-type: none"> <li>- "Monitor for any c/o [complaints of] frequency, urgency, odorous urine, changing color, burning,</li> <li>- Assist with peri-care, assess for any redness or skin breakdown, and notify LPN,</li> <li>- Encourage fluids,</li> <li>- [Increase] monitoring while toileting and assure excellent peri-hygiene is given [after] BM [bowel movement] to [decrease] [number] of UTI's [with] E. Coli bacteria..."</li> </ul> <p>The facility's Urinary Incontinence-Clinical Protocol documented in part the following:</p> <ul style="list-style-type: none"> <li>- The goal of treatment in most cases for UTI's is to control signs and symptoms of infection, not eliminate bacteriuria.</li> </ul> | F 315 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                              |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>135075</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>08/16/2013</b> |
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| F 315   | <p>Continued From page 27</p> <ul style="list-style-type: none"> <li>- Antibiotic treatment is not indicated routinely for the treatment of UTI's,</li> <li>- When someone's urinary tract infection persists or recurs after treatment with an initial course of antibiotics, the physician should review the situation carefully with the nursing staff and possibly examine the individual before prescribing repeated courses of antibiotics,</li> <li>- Physicians should justify continuing or resuming antibiotic treatment beyond an initial course of treatment...</li> </ul> <p>Interdisciplinary Progress Notes documented the following:</p> <ul style="list-style-type: none"> <li>* On 3/26/13 at 9:00 a.m., "Per faxed communication [with] pcp [primary care provider], resident is to begin Cipro for UTI..."</li> <li>- "10:15 a.m...First dose of Cipro 250 mg this AM..."</li> <li>- "1430 [2:30 pm] Per faxed communication [with] pcp, Cipro to be dc'd [discontinued] and resident is to begin taking Augmentin..."</li> <li>* On 3/27/13 at 0045 [12:45 am],... "Cont[inue] ABT [antibiotic] for UTI."</li> <li>- "11:00 a.m...cont[inues] PO [by mouth] Cipro [without] s/s ASE [adverse side effects]."</li> <li>* On 3/27/13 at 10:21 a.m., the culture and sensitivity results of the UA identified the bacteria was E Coli and that E Coli was resistant to Cipro. A hand written note without a date or initial, on the lab result documented, "(not) [changed] to Augmentin [secondary] to PCN allergy."</li> </ul> <p>NOTE: The IPN did not document why the Augmentin was discontinued. It did however, document that Resident #3's UTI was treated with Cipro which would not be an effective treatment as the lab had identified the E Coli was resistant to Cipro. The resident continued to receive the Cipro 250 mg twice daily for 5 days</p> | F 315   |   |   |

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

PRINTED: 11/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |   |
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| F 315 | <p>Continued From page 28</p> <p>A "Primary Physician Fax," which was faxed to the physician on 7/30/13, documented the following:</p> <p>"1. UTI in March = E-Coli; tx [treatment] [with] Macrobid 100 mg BID [twice daily] x 7 days.<br/>2. UTI in March = E-Coli; tx [treatment] [with] Cipro 250 mg BID [twice daily] x 5 days.<br/>3. UTI in April = E-Coli; tx [treatment] [with] Rocephin 1gr[am] IM [Intramuscular] x 3 days.<br/>4. UTI in May = E-Coli; tx [treatment] [with] Macrobid 100 mg BID [twice daily] x 10 days.<br/>5. UTI in July = E-Coli; currently [treatment] [with] Macrobid 100 mg BID [twice daily] x 10 days.<br/>Each culture shows susceptible to Macrobid.<br/>* Would it be appropriate to send a post abx UA (urinalysis)<br/>* Would it be appropriate treating her prophylactically? She is symptomatic with these UTI's.<br/>* Possible referral to urologist? Per F315 guidelines."<br/>The Physician's only response/recommendation was, "Macrobid 100 mg po q hs [by mouth every night at bedtime] 6 months.<br/>There was no evidence of follow-up by the facility regarding the physician's response.</p> <p>Additional information provided to the Bureau of Facility Standards via fax from the Wound/Infection Control Nurse on 8/19/13 and dated 8/17/13 was reviewed and included, in part, the following documentation:<br/>* "2/13...Cipro ordered. C&amp;S (culture and sensitivity) = E-Coli. Changed to Macrobid 100 mg PO BID [by mouth twice a day] x 5 days."<br/>* "3/13...Cipro ordered. C&amp;S (culture and sensitivity) = E-Coli. Changed to Ceftin 250 mg PO BID [by mouth twice a day] x 5 days."</p> | F 315 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/27/2013  
FORM APPROVED  
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| F 315 | <p>Continued From page 29</p> <ul style="list-style-type: none"> <li>* "4/13... C&amp;S (culture and sensitivity) = E-Coli. Rochephin IM x 3 days.</li> <li>* "7/13... C&amp;S = E-Coli. Changed to Macrobid 100 mg PO BID [by mouth twice a day] x 10 days."</li> <li>* "This resident is in the behavior unit and is a poor historian with the diagnoses of dementia and psychosis. I believe it is questionable whether or not she had UTI's these months or whether she is colonized, as looking at the lab values they are basically consistent month to month."</li> <li>* "8/17...I requested a referral to a urologist from the PCP in July as well as an order for prophylactic antibiotic. No referral has been received at this time. Plan to discuss with son this afternoon whether the family wishes a urology referral or not and will proceed from there."</li> </ul> <p>The Primary Physician fax and the additional information faxed to the facility did not contain the same information related to Resident #3's timeline of UTI's with treatments provided. The infection control nurse states she questioned whether or not the Resident had UTI's these months or whether she [Resident #] is colonized, but asks the Physician for prophylactic treatment. In addition, the facility waited until 7/30/13 and 6 UTI's to request a urology consult and 6 months to discuss a urology consult with the resident's son.</p> <p>Resident #3 had 7 documented UTI's within a 6 month time frame and each time the bacteria from the Culture and Sensitivity grew E. Coli and the resident was treated with an antibiotic. There was no documentation to indicate, the physician had reviewed the situation carefully with nursing staff before prescribing repeated courses antibiotics, as directed by the facility's policy for Resident #3.</p> | F 315 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/27/2013  
FORM APPROVED  
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| F 315   | Continued From page 30   | F 315   |   |   |
| F 323<br>SS=G   | <p>On 8/14/13 the DNS and BCPM were informed related to the resident's chronic history of UTI's. No additional information was provided at the time.</p> <p><b>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b></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:<br/>Based on observation, record review, staff interviews, and review of Accident/Incident Reports, it was determined the facility failed to ensure the safety of residents from accidents, including falls, safe water temperatures, and that storage rooms with harmful chemicals inside were locked when unattended. This was true for 2 of 13 residents (#6 and #10) sampled for falls, any resident showered in the East Shower Room, and any cognitively impaired resident who could access the unlocked storage room. Resident #6 was harmed when a CNA rolled the resident off the edge of the bed and he suffered a right orbital fracture, hematoma and contusions. Resident #10 had 13 falls within 6 months which created the potential for harm. Findings include:</p> <p>1. Resident #6 was readmitted to the facility on 11/8/11 with multiple diagnoses, which included</p> | F 323   | <p>1. Resident #6 had interventions for fall prevention put in place on 5/10/13 and no further falls have occurred. Resident #10 has had new interventions put into place on 8/13/13. A new mixer valve was placed in the shower room on 9/6/13 to allow for water temperature regulation within adequate range. The tub room and shower room remodel was underway at survey time. The door to the storage area had a self-locking door knob installed by 8/20/13.</p> <p>2. All residents have the potential to be affected. Through admit assessment, quarterly MDS review and prn change of status review residents will be identified for care planning updates. Routine reviews will be done to monitor water temps and door security.</p> | 9/16/13   |

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

PRINTED: 11/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

|   |   |   |   |                      |   |
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| F 323   | <p>Continued From page 31<br/>degenerative arthritis, paraplegia, chronic pain, dementia, congestive heart failure, hypertension and chronic obstructive pulmonary disease.</p> <p>Resident #6's age at the time of the fall was 75 years old. The resident's annual MDS dated 12/7/12 and/or quarterly MDS dated 5/17/13 documented the following:<br/>* Resident totally dependent on 2+ staff for personal hygiene<br/>* Resident has ROM limitations in upper and lower extremities on both sides<br/>* Resident height 65" and weight 195 pounds</p> <p>Resident #6's Fall Risk Assessments for 2/28/13 and 12/7/12 showed the resident at high risk for falls.</p> <p>The resident's ADL Care Plan dated 3/5/13 documented under the Bed Mobility section "to handle with care as hx (history) RT (Right) hip/and leg bones pathological fractures." The Personal Hygiene section documented, "Total 1-2 assist for peri-care." The Side Rails/Safety section documented "Bed lowest position when occupied. Full rails down. Concave mattress, alternating air, 15 minute checks."</p> <p>An Accident/Incident Report dated 5/6/13 documented CNA #9 had changed Resident #6 in bed and the, "resident fell off the side of the bed, large hematoma above the right eye." The resident was sent to the ER (Emergency Room) via ambulance for evaluation.</p> <p>An Emergency Department (ED) report for Resident #6, dated 5/6/13, documented the resident, "presents moaning and repeatedly</p> | F 323   | <p>3. In servicing done for nursing staff on accident training, prevention and management beginning on 9/4/13 and ongoing.<br/>Weekly QA rounds for 4 weeks and then monthly for 3 months beginning on 9/10/13.</p> <p>4. The DNS and Maintenance Director or their designees will follow this issue in QA review as stated above and report monthly to the QA committee beginning with the September QA meeting.</p> |                      |   |

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

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| F 323   | <p>Continued From page 32</p> <p>exclaiming in pain, nonverbalizing." The Objective Assessment section documented, "the right eye is swollen shut with ecchymosis (hematoma) of the upper lid."</p> <p>A CT (Contrast) scan of the head dated 5/6/13 reported slightly depressed right orbital floor fracture (fracture of bones surrounding the eye), large right preseptal (nasal septum) orbital hematoma, and blood within the right maxillary sinus. The final diagnosis documents an orbital floor fracture of the right orbit and multiple facial contusions secondary to the fall.</p> <p>An Investigation Report form (IR) dated 5/10/13 documented, "staff mistake." CNA #9 documented in his personal statement dated 5/7/13, "I turned him to one to start cleaning a side [sic]. I got him clean and rolled up his liner and peach pad on him and tucked it under him. I forgot to put up his rail and turned him on to the other side and was going to perform the rest of pericare but had to change gloves, so while having my hands on him I reached for the box of gloves on the bed. As I did, he complained of hip pain and started wiggling and he fell of the bed."</p> <p>The IR Summary findings document CNA #9 should have rolled Resident #6 towards him instead of away from him and should have had supplies within easy reach. The summary documented contributing factors included the resident is obese and there, "was not a lot of room on the bed after being turned," had pain issues and was uncomfortable and moved. The IR Summary documented the CNA made a mistake by rolling the resident away from him instead of toward him and, "not having incontinent supplies ready and handy."</p> | F 323   |   |   |

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

PRINTED: 11/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

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|--------------------|--|---------------|---|----------------------|
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| F 323 | <p>Continued From page 33</p> <p>The IR documents corrective action taken included the CNA received disciplinary action for rolling the resident away from him when providing cares. The Care Plan was updated to have 2 staff provide incontinent care.</p> <p>On 8/16/13 at 10:30 AM, the DON was interviewed about the proper procedure for rolling a resident to provide cares. The DON stated she didn't know but would look it up. She referenced a book titled Nursing Assistant, copyright 1998, and then suggested we talk with the Wound Nurse as she does training of CNAs. At 10:38 AM, the Wound Nurse was interviewed about proper procedure for rolling a resident to provide cares and she stated rolling a resident towards you is the proper procedure.</p> <p>A fax dated 8/19/13 from the facility documented after further investigation, the CNA had been trained to turn the resident away from him during peri-care. The faxed document indicated administration spoke to the [Facility] CNA instructor on 8/16/13 who showed them a book the CNA was taught with, however, the fax did not provide a book title, edition or year. The facility stated, "after re-looking at this, we believe our initial conclusion in May was inaccurate." The facility also reported the CNA could not have predicted Resident #6 was going to start "wiggling" and have hip pain during this peri-care incident.</p> <p>Progress Notes dated 4/18/13 (prior to fall) document, "He still gets PRN Norco 7.5 1-3 times a day, and has been on scheduled MS (morphine sulfate) 60 mg BID since 1/29/13." Review of the resident's MAR's for April of 2013 document the resident received Norco 7.5 mg/325 mg 1-2 tabs</p> | F 323 |  |  |
|-------|---|-------|--|--|

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

PRINTED: 11/27/2013  
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OMB NO. 0938-0391

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>VALLEY VISTA CARE CTR OF ST MARIES</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>820 ELM STREET<br/>ST MARIES, ID 83861</b>                          |                      |   |
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| F 323   | <p>Continued From page 34</p> <p>PRN pain 49 times for hip pain. Between 5/1 - 5/6/13, prior to the fall the resident received Norco 11 times for hip pain. Resident #6's Staffing Report for the Annual MDS Assessment dated 12/7/12, and the Quarterly MDS Assessment dated 2/28/13, documented "Pain will always be an issue."</p> <p>Mosby's Textbook for NURSING ASSISTANTS, 6th Edition, Copyright 2004, Chapter 13 Body Mechanics, moving the person to the side of the bed, page 249, documents, "Rock backward to move the lower part of the person toward you. Repeat the procedure for the legs and feet." Additionally, on page 250 in "Focus On Older Persons" it documents, "Many older persons suffer from arthritis...it is best to use the logrolling procedure..." When logrolling the person, page 253 of Chapter 13 Body Mechanics, documents to roll the person toward you, or use a turn sheet.</p> <p>The facility failed to ensure the safety of Resident #6 was free from falls. The resident experienced harm when a CNA rolled the resident off the edge of the bed on to the floor resulting in pain from an orbital fracture, hematoma and multiple contusions.</p> <p>2. On 8/13/13 at 8:20 AM, the water temperature in the East Shower Room was found to be at 133 degrees Fahrenheit (F). The Maintenance Supervisor (MS) witnessed the 133 degree F temperature and stated it was too high. The MS stated he would turn down the thermostat.</p> <p>Later at 9:35 AM, the water temperature was checked again by the surveyor in the East Shower Room and was found to be 126 degrees F. The MS checked the temperature with his</p> | F 323   |   |                      |   |

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

PRINTED: 11/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

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| F 323   | <p>Continued From page 35</p> <p>thermometer which confirmed the water temperature was 126 degrees F. The MS stated he would turn down the thermostat again. At that time the MS contacted a professional plumber to recalibrate the water temperature.</p> <p>Water temperature can reach hazardous temperatures which put residents at risk for burns caused by scalding. Water temperature at 133 degrees F for 15 seconds can cause a 3rd Degree Burn.</p> <p>3. During the Environmental Tour on 8/14/13 at 3:00 PM, the storage room next to the Common Area was observed to be unlocked. The storage room contained: Denture Cleanser (12 boxes), Body Wash, Turbo Clean (Cleanser for jet tub, 8 gallon containers), Cid-A-L II Disinfectant (3 gallon containers), numerous containers of Natural Bath Oil which stated for external use only. The MS was present and stated the closet should be locked.</p> <p>4. Resident #10 was admitted to the facility on 9/10/12 with multiple diagnoses to include, dementia, psychosis, anxiety, depression, femoral artery occlusion, and venous stasis ulcer.</p> <p>The resident's Significant Change MDS dated 7/30/13, coded the following:<br/>         *Sometimes has the ability to understand others and make self understood,<br/>         *Inattention and disorganized thinking - behavior consistent over time,<br/>         *Cognition is severely impaired,<br/>         *Extensive assist of two people for transfers, bed mobility, toileting, and personal hygiene.<br/>         *Total assist of two people for bathing.</p> | F 323   |   |   |

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

PRINTED: 11/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

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|--------------------|--|---------------|---|----------------------|
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| F 323 | <p>Continued From page 36</p> <p>NOTE: The only dates documented on the following care plan was the "Origin dates" which indicated the original date the "Problem was identified and the "Estimated Date" which indicated the date the identified goal should be met. It could not be determined when the Care Plan Focus Area and Intervention areas were reviewed or revised.</p> <p>Resident #10's Care Plan documented the following:<br/>Problem #5 dated 9/14/12, Potential for Falls/Fall Prevention documented the following interventions:<br/>* Evaluate risk factors &amp; modify as needed for fall prevention: see fall risk assessment form in MDS section.<br/>* Keep bed in low position; ergonomically [sic] correct for safe entry/exit from bed 12/22/12.<br/>* Orient to surroundings, and introduce self when entering room.<br/>* Fall risk assessment quarterly and prn.<br/>* Continue toileting program already in place.<br/>* Keep in line of sight when agiated [sic] or with intrusive behaviors.<br/>* Falling star program will be initiated when fall occurs and for 30 days following a fall. Note: A resident on the falling star program has a star placed on their name plate outside of his/her room to alert staff that the resident is at increased risk for falls. As staff walk down the hall they are to look in the rooms of those residents with the stars to ensure the resident is safe and assess potential needs.</p> <p>The following documents were reviewed: Accident/Incident Report, Resident Incident Report, IPNs in the resident's record and the Fall Scene Investigation Report (FSI). Resident #10</p> | F 323 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

|   |   |  |   |
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|--------------------|---|---------------|---|----------------------|
| F 323              | <p>Continued From page 37</p> <p>had thirteen documented falls between 2/17/13 and 8/12/13, including the following:</p> <ul style="list-style-type: none"> <li>- On 6/6/13 at 2:45 a.m., the IPN documented, "...Resident found on floor crawling out of bedroom into the hall. States, '...be quiet [husband's name] sleeping,' Appears to have gotten out of bed onto the floor."</li> <li>* The Accident/Incident Report included the following documentation under describe accident, "... appears she crawled out of bed [and] to the doorway to get assistance..." Documented under, if unwitnessed investigate accident cause, "...No fall noise was heard believe pt [patient] got out of bed and crawled to bedroom doorway." Documented under Description of preventive measures taken to prevent incident/accident from recurring.. "assessed pt [patient] continue to anticipate needs."</li> <li>- On 6/25/13 at 8:20 p.m., the IPN documented, "Res[ident] had a slide from chair injury...receiving hematoma to [right] forehead..."</li> <li>* The Resident Incident Report (RIR) documented, "Res[ident] has a habit of pulling on objects to self propel w/c. Pulled at table edge in dining area, lost balance and slid out of w/c hitting right side of head on floor receiving a hematoma."</li> <li>** The FSI documented the following:<br/>"What appears to be the root cause of the fall? WC cushion did not have cover on it which made it slick."<br/>"Describe initial interventions to prevent future falls. Will order wedge cushion. Added cover to wc cushion."</li> <li>- On 7/29/13 at 1820 [6:20 p.m.], the IPN documented, " [at] 1540 [3:40 p.m.] resident was found in [sic] floor in front of her w/c in her room.</li> </ul> | F 323         |   |                      |

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

PRINTED: 11/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

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|--------------------|--|---------------|---|----------------------|
| F 323              | <p>Continued From page 38</p> <p>States she hit her head...[Resident's name] has been extremely agitated this shift prior to accident."</p> <p>* The RIR documented, "Resident was in room. Staff heard a loud noisy [sic] from her room. Upon staff entering, resident found on floor in front of w/c on her back. States she hit her head."</p> <p>** The FSI documented the following:<br/>"Factors observed at the time of fall. Wheel chair brakes unlocked."<br/>"What type of assistance was resident receiving at time of fall? Alone and unassisted."<br/>"What appears to be the root cause of the fall? Agitation [increased] behaviors [secondary] to dressing [change] to LE [lower extremity]."<br/>"Describe initial interventions to prevent future falls: "Monitor more closely when agitated [secondary] to signif[icant] others visit."</p> <p>On 8/3/13 at 8:30 a.m., the IPN documented, "NIF [non-injury fall] see attached accident report."</p> <p>* The RIR documented the following, "Staff heard resident calling out for [husband's name] checked on res[ident] found res[ident] sitting on floor next to bed. Res[ident] stated I should not have tried to get up by myself. Res[ident] fell between her bed [and] roommates."</p> <p>** The FSI documented the following:<br/>"Factors observed at time of fall. Resident demented."<br/>"What type of assistance was resident receiving at time of fall? Alone and unattended."<br/>"What appears to be the root cause of the fall? Dementia and poor safety awareness."<br/>"Describe initial interventions to prevent future falls: Already on the falling star program. Do not leave unattended in room in w/c."</p> | F 323         |   |                      |

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

PRINTED: 11/27/2013  
FORM APPROVED  
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|  |   |  |   |
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| F 323 | <p>Continued From page 39</p> <p>On 8/12/13 at 8:00 a.m., the IPN documented, "Res[ident] had NIF [non-injury fall], see accident report."</p> <p>* The RIR documented the following, "Res[ident] found lying on her [right] side [at] the foot of her bed. Res[ident] stated she was chasing dog out the house."</p> <p>** The FSI documented the following:<br/>"What type of assistance was the resident receiving at time of fall? Alone and unattended."<br/>"What appears to be the root cause of the fall? Dementia, poor safety awareness..."<br/>"Describe initial interventions to prevent future falls: Motion alarm at bedside when in bed. 8/13/13"</p> <p>On 8 /14/13 the DNS and Administrator were interviewed about Resident #10's multiple falls. No additional information was provided at that time.</p> <p>On 8/19/13 the Bureau of Facility Standards received additional faxed information from the facility regarding the resident's falls and the supervision provided. The fax documented in part:<br/>- "After the 2/17/13 fall, the resident's care plan was updated to say, 'Keep res[ident] in line of sight when agitated.<br/>The Accident/Incident Report dated 2/17/13, "Res[ident] found on floor on her left side...It appears as if she were [sic] to get in closet and pulled herself out of w/c."<br/>The Accident/Incident Report dated 2/22/13, "Suspect res[ident] was attempting to toilet self [and] fell."<br/>The Accident/Incident Report dated 2/24/13, "Resident stood up at sink- w/c rolled backwards [and] res[ident] fell landing on Right side..."</p> | F 323 |  |  |
|-------|--|-------|--|--|

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

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| F 323   | Continued From page 40<br>None of the above Accident/Incident Reports documented the resident was agitated prior to falls. Each Report does however, documented the falls were associated with the resident's unmet needs.<br><br>- "On 4/12/13, she [Resident #10] was moved to a room closer to the nurse's station." The facility indicated this intervention met the definition of increased supervision; however, Resident #10 had 5 documented falls after 4/12/13 when her room was moved closer to the nurse's station.<br><br>- On 4/29/13, "This resident [Resident #10] was moved to the secure behavior unit. That alone increased her supervision as there is a higher staffing ratio."<br><br>Resident #10 had 5 documented falls after she was moved to the secured behavior unit which had a higher staffing ratio. The facility's failure to ensure that interventions were implemented correctly and consistently, evaluate the effectiveness of the interventions, modify and/or replace interventions as needed and evaluate the effectiveness of the new interventions led to the continued falls for Resident #10. | F 323   |   |   |
| 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   | F 329   | 1. Resident # 10 Hospice contacted MD regarding the scheduling of this medication routinely on 8/13/13. Resident #2 MD was notified for possible gradual dose reduction on 8/19/13. | 9/16/13   |

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

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| F 329   | <p>Continued From page 41<br/>should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on medical record review and staff interviews, it was determined the facility failed provide gradual dose reductions (GDR) for antidepressant medications and justification for multiple antidepressant and benzodiazepine use, including PRN (as needed) medications. This was true for 2 of 16 sampled residents (#2 &amp; 10). This practice created the potential for harm should the medication regimen result in or contributed to an unanticipated decline and/or newly emerging or worsening symptoms. Findings included:</p> <p>1. Resident #10 was admitted to the facility on 9/10/12 with multiple diagnoses to include, dementia, psychosis, anxiety, depression, femoral artery occlusion, and venous stasis ulcer.</p> <p>The Resident's Significant change MDS dated</p> | F 329   | <p>2. All residents on a psychotropic medication have the potential to be affected. Through admit assessment, Monthly Pharmacy review and prn change of status review residents prescribed psychotropic medications will be identified for care planning, assessment, documentation needs and dose reduction requirements. Residents on dual therapy were reviewed by BCC by 9/4/13. Residents requiring assessment for possible GDRs were also reviewed by 9/4/13 for timely completion.</p> <p>3. In servicing done for nursing staff on assessment and follow up regarding the use of psychotropic medications beginning on 9/4/13 and ongoing. Weekly QA rounds for 4 weeks and then monthly for 3 months beginning on 9/10/13.</p> <p>4. The DNS or her designee will follow this issue in QA review as stated above and report monthly to the QA committee beginning with the September QA meeting.</p> |                      |   |

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

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|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

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| F 329 | <p>Continued From page 42<br/>7/30/13, coded the following:<br/>*Sometimes has the ability to understand others and make self understood,<br/>*Inattention and disorganized thinking - behavior consistent over time,<br/>*Cognition is severely impaired.</p> <p>Resident #10's Physician Order Report dated 8/1/13 documented the following orders:<br/>*Clonazepam (Klonopin) 0.5 mg by mouth twice a day as needed - Anxiety<br/>*Ativan 0.5 mg by mouth or intramuscular every 8 hours as needed - Anxiety with Agitation<br/>*Lexapro 10 mg by mouth every morning - Depression<br/>*Nortriptyline 50 mg by mouth every day at 5 p.m.</p> <p>a) Federal guidance at F329 indicated, "...'Duplicate therapy' refers to multiple medications of the same pharmacological class/category or any medication therapy that substantially duplicates a particular effect of another medication that the individual is taking...Under these regulations, medication management includes consideration of...III. Dose (including duplicate therapy)...A documented clinical rationale for the benefit of, or necessity for, the dose or for the use of multiple medications from the same pharmacological class...Documentation is necessary to clarify the rationale for &amp; benefits of duplicate therapy &amp; the approach to monitoring for benefits &amp; adverse consequences..."</p> <p>A Psychoactive Medication Informed Consent form dated 3/13/13 documented the following:<br/>*"The following less restrictive non-drug approaches have proven to be INEFFECTIVE: Nortriptyline 25 mg."</p> | F 329 |  |  |
|-------|--|-------|--|--|

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

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| F 329 | <p>Continued From page 43</p> <p>* "Medication intervention recommended: Nortriptyline 50 mg po Q 1700 [by mouth ever day at 5 p.m.]."</p> <p>The facility documented the Nortriptyline 25 mg was an ineffective non-drug approach but the resident remained on it, with an increase in the dose to 50 mg. In addition, it is unclear why Nortriptyline was identified as a non-drug approach.</p> <p>[Facility name]/Physician Progress Notes dated 3/27/13 documented the following:<br/>* "Lexapro was decreased to 10 mg daily at the pharmacy's recommendation because of combining with the other antidepressant (amitriptyline). It is unclear whether there has been a change in her depression or anxiety since then... If there is any increase in anxiety or depressive symptoms, increasing Lexapro back to 20 mg daily should be considered," followed by the [Psychiatrist's name] and signature.<br/>* "She has required very few prn dosages of Ativan, so a gradual taper of Klonopin was discussed..."</p> <p>The Nursing 2013 Drug Handbook defines Clonazepam as a benzodiazepine that has the potential to cause the following adverse reactions in the CNS (central nervous system) drowsiness, agitation, behavioral disturbances, confusion, and depression. In addition, nursing considerations included, "Assess elderly patient's response closely. Elderly patients are more sensitive to drug's CNS effects."</p> <p>The Nursing 2013 Drug Handbook defines Ativan as a benzodiazepine that has the potential to cause the following adverse reactions in the CNS,</p> | F 329 |  |  |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/27/2013  
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>135075</b>  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                   | (X3) DATE SURVEY COMPLETED<br><br><b>08/16/2013</b>   |                      |
|---|--|--|---|----------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>VALLEY VISTA CARE CTR OF ST MARIES</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>820 ELM STREET<br/>ST MARIES, ID 83861</b> |   |                      |
| (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 329   | <p>Continued From page 44</p> <p>drowsiness, sedation, insomnia, agitation, unsteadiness, disorientation, and depression. In addition, contraindications &amp; cautions included, contraindicated in patients using other benzodiazepines and use cautiously in the elderly.</p> <p>b) Resident #10 resided in the secure unit. The facility uses a form, "Escalating Behavior Protocol" for every resident on the secured unit that has an order for a PRN antianxiety or antipsychotic medication order. The form is generic and lists three phases of "agitation" with corresponding "appropriate interventions" as identified by the staff. The CNA's initiate the form when the resident begins to show early signs of agitation and according to the form is only "active" for a maximum of 45 minutes. After the 45 minutes if the resident begins to display signs of agitation again a new form is started.</p> <p>An "Escalating Behavior Protocol" documented the following:<br/>* On 7/2/13 at 3:40 p.m., the behavior form was initiated and Resident #10 received Ativan (unknown dose) at 4:35 p.m. and at 6:00 p.m. received Clonazepam (unknown dose) and Morphine (unknown dose) for agitation. There was no escalating behavior form filled out prior to administer the 6:00 p.m. does of Clonazepam. The Clonazepam was documented on the 3:40 p.m. behavior form.</p> <p>The facility identified the resident's Phase One signs of agitation as: wandering, becomes confused, moving articles in her room, and resisting care. The facility's interventions for the resident were: assess and meet needs, re-assurance, look at photos with her, offer to get</p> | F 329  |   |                      |

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| F 329   | <p>Continued From page 45</p> <p>up/lay down, and validate concerns. Phase Two signs were: verbal aggression, becomes more confused, constant crying... Interventions included, change environment, take for a walk , 1:1 attention, change staff, organize room with her, offer pop. Phase Three signs were: refuses redirection, attempts to stand, becomes more verbally aggressive, and physical aggression. Interventions included: assess and meet needs, attempt to redirect, quite area, and prn.</p> <p>The resident at baseline wanders, and is confused yet the facility has identified these things as, "early signs of aggitation." In addition, "Moving articles in her room," was identified as aggitation but her Potential for Diversional Activity care plan, documented: "Resident states the following is very important, taking care of personal belongings." The form does not include giving the resident space as an intervention which the BCPM indicated is an important intervention for Resident #10. (Refer to F309 for additional details regarding this issue).</p> <p>* On 8/2/13 at 8:10 a.m., the behavior form was initiated and Resident #10 received Clonazepam 0.5 mg at 8:30 a.m. and Ativan 0.5 mg at 9:00 a.m. for aggitation. The facility identified the resident's Phase One signs of agitation as becomes confused. There were no interventions documented. Phase Two, verbal aggression, and calling out for husband [husband's name]. There were no interventions documented. Phase Three, profanity in common area. There were no interventions documented except the administration of Clonazepam at 8:30 a.m. and the Ativan one half hour later at 9:00 a.m.</p> <p>*On 8/6/13 at 1:30 a.m. the behavior form was</p> | F 329   |   |   |

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| F 329              | <p>Continued From page 46</p> <p>initiated and Resident #10 received a IM injection of Ativan after the nurse, "Attempted to give PO Klonopin but [resident] knocked [it] onto the floor. Gave Ativan IM." The resident had already been given Klonopin po at 12:00 a.m.</p> <p>The protocol was initiated at 1:30 a.m., in the middle of the night, and within a 45 minute time frame the facility identified the resident was wandering, confused, moving articles in her room, resisting care, verbally aggressive, talking about people stealing her car, wanted police called, more confused, constant crying, refuses redirection, attempted to stand, more verbally aggressive, and physical aggression. The facility identified they had also tried every intervention listed on the behavioral form. The resident refused to take the Klonopin and instead of giving the resident space, the nurse gave the resident an IM injection of Ativan.</p> <p>* On 8/7/13 at 4:15 p.m., the Resident received Clonazepam (unknown dose) and at 5:15 p.m., one hour later, received Ativan (unknown dose) for aggitation. There was only one escalating behavior sheet filled out and it was for 4:15 p.m.</p> <p>* On 8/8/13 at 4:30 p.m. the Resident received Clonazepam 0.5 mg and at 7:30 p.m. received Ativan 0.5 mg and Morphine solution 0.5 ml for agitation. There was only one escalating behavior sheet filled out and it was for 4:30 p.m.</p> <p>The facility documented the Morphine was given in addition to the Ativan at 7:30 p.m. for agitation; however agitation by itself is not an indicated use for Morphine.</p> <p>* On 8/9/13 at 3:20 p.m., the Resident received</p> | F 329         |   |                      |

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| F 329              | <p>Continued From page 47</p> <p>Ativan 0.5 mg and Morphine 0.5 ml and at 7:30 p.m. Clonazepam 0.5 mg and Morphine 0.5 ml for escalated behaviors.</p> <p>On 8/15/13 the DNS was interviewed about the duplicate therapy of antidepressants and benzodiazepines. She was unable to produce documentation from the psychiatrist or primary care physician to support the justification of dual drug therapy for Resident #10.</p> <p>2. Resident #2 was admitted 8/04/06 with diagnoses which included Huntington's Chorea, dementia, depression, pain and expressive aphasia (ability to talk).</p> <p>Review of Resident #2's most recent quarterly MDS assessment, dated 5/24/13, documented the resident received an antidepressant medication.</p> <p>Resident #2's 8/1/13 Physician Orders included an order for Anafranil (antidepressant) 100 mg every day for obsessive compulsive disorder/depression with a start date on 5/24/12.</p> <p>A Consultant Pharmacist's Medication Regimen Review (CPMRR) documented the review was created between 7/1/13 and 7/31/13. The CPMRR documented the resident had received 100 mg for 1 year and should be reviewed for a dose reduction. The form included areas to check by the physician if a reduction was indicated or if a reduction was contraindicated and the rationale it was contraindicated. The form was not checked in either area and was not signed by the physician.</p> <p>A 7/23/13 Interdisciplinary Progress Note documented a fax from the physician</p> | F 329         |   |                      |

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| F 329  | Continued From page 48<br>recommended no medication changes. The 7/22/13 fax for the "Primary Physician Fax" listed 4 residents and included Resident #2. The fax documented there were to be no changes to Resident #2's Anafranil, but did not document any reason the reduction was contraindicated.<br><br>On 8/15/13 the DON stated the physician had not provided rationale the reduction of the Anafranil was contraindicated.   | F 329  |  |                      |  |
| F 441<br>SS=D  | 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. | F 441  | 1. Staff identified that were caring for the resident attended training on 8/13/13 on hand washing and the use of hand sanitizer at the time of notification.<br>2. All residents have the potential to be affected.<br>3. In servicing done for nursing staff on proper hand washing and sanitizing beginning on 9/4/13 and ongoing. Weekly QA rounds for 4 weeks and then monthly for 3 months beginning on 9/10/13.<br>4. The DNS or her designee will follow this issue in QA review as stated above and report monthly to the QA committee beginning with the September QA meeting. | 9/16/13              |  |

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| F 441   | <p>Continued From page 49</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted 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 observation and staff interview, it was determined the facility failed to ensure infection control measures were consistently implemented. This was true for 3 of 13 sampled residents (#s 2, 3, and 8). Failure to follow hand hygiene procedures placed residents at risk for infections. Findings included:</p> <p>1. Resident #2 was admitted to the facility 8/04/06 with diagnoses which included Huntington's Chorea, dementia, depression, pain and expressive aphasia (ability to talk).</p> <p>Resident #2's most recent quarterly MDS assessment, dated 5/24/13, documented she required extensive assistance of one staff for transfers and toilet use, and extensive assistance of two staff for personal hygiene.</p> <p>During an observation, on 8/13/13 at 8:00 a.m., CNA #1 and CNA #2 were observed as they walked with Resident #2 to the toilet. After Resident #2 used the toilet she stood and held the handbar. CNA #1 removed the Attends and CNA #2 used a disposable wipe to provide</p> | F 441  |   |                      |

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| F 441   | <p>Continued From page 50</p> <p>pericare to the resident. The CNAs walked with the resident and seated her in her wheelchair. The CNAs did not wash their hands after the resident was seated in her wheelchair. CNA #1 then went to get a wash cloth to wash the resident's face. At that time both CNAs were asked if they had washed their hands and they stated no. CNA #1 stated she should have washed her hands prior to washing the resident's face.</p> <p>2. Resident #3 was admitted to the facility on 6/3/2011 with multiple diagnoses to include, Alzheimer's, rheumatoid arthritis, fibromyalgia, depression, and generalized pain.</p> <p>Resident #3's Quarterly MDS dated 5/31/13, coded in part the following:</p> <ul style="list-style-type: none"> <li>- Makes self understood and has the ability to understand others - sometimes,</li> <li>- Cognition severely impaired,</li> <li>- Extensive assist of one person for toileting and personal hygiene.</li> </ul> <p>During an observation on 8/13/13 at 10:30 a.m., Resident #3 was observed to use the bathroom with assistance from CNA #1. The resident was instructed and assisted by CNA #1 to wash her hands. The CNA prompted the resident to use soap and the resident declined. The CNA handed the resident a towel to wipe her hands off and then the two of them walked hand in hand down the hall. The CNA did not wash her hands after walking hand in hand with the resident down the hall.</p> <p>3. Resident #8 was admitted to the facility on 2/15/12 with multiple diagnoses to include, Alzheimer's, anxiety, diabetes with ophthalmic</p> | F 441   |   |   |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 441 | <p>Continued From page 51 manifestations, and osteoarthritis.</p> <p>During an observation on 8/13/13 at 10:05 a.m., Resident #8 was observed to use the bathroom with assistance from CNA #1. The resident was instructed and assisted by CNA #1 to wash her hands. The CNA prompted the resident to use soap and the resident declined. The resident dried her hands off with a towel and walked down the hall with her left hand held by CNA #1 and her right hand positioned on the handrail for approximately 30 feet of the railing. The CNA did not wash her hands after walking with the resident nor did she clean the handrail.</p> <p>On 8/14/13 at 5:30 p.m. CNA #1 was interviewed related to the above observation. The CNA said she should have used a saniwipe, put soap in a washcloth and handed it to the residents, put soap in her hands and then washed the resident's hands, or given the resident some hand sanitizer.</p> | F 441 |  |  |
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STREET ADDRESS, CITY, STATE, ZIP CODE  
**820 ELM STREET  
ST MARIES, ID 83861**

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| C 000              | <p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiencies were cited during the State licensure survey of your facility.</p> <p>The surveyors conducting the survey were:<br/>Brad Perry, BSW, LSW, Team Coordinator<br/>Sherri Case, BSW, LSW, QMRP<br/>Amy Jensen, RN<br/>Becky Thomas, RN</p> | C 000         | <p><b>RECEIVED</b><br/><b>DEC 12 2013</b><br/><b>FACILITY STANDARDS</b></p>                                     |                    |
| C 125              | <p>02.100.03,c,ix Treated with Respect/Dignity</p> <p>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 as it relates to dignity.</p>  | C 125         | See F Tag 241   | 9/16/13            |
| C 147              | <p>02.100.05,g Prohibited Uses of Chemical Restraints</p> <p>g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician.<br/>This Rule is not met as evidenced by:</p>                        | C 147         | See F Tag 329   | 9/16/13            |

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

*Bryan V. Sawyer*

TITLE  
**NHA**

(X6) DATE  
**12/10/13**

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| C 147              | Continued From page 1<br>Please refer to F329 as it relates to unnecessary drugs.   | C 147         |   |                    |
| C 342              | 02.108,04,b,ii Toxics Stored Under Lock and Key<br><br>ii. All toxic chemicals shall be properly labeled and stored under lock and key.<br>This Rule is not met as evidenced by:<br>Please refer to F-323 as it refers to an unlocked storage closet containing chemicals.  | C 342         | See F Tag 323   | 9/16/13            |
| C 445              | 02.120,13,c Hot Water Temps 105-120 Degrees F<br><br>c. The temperature of hot water at plumbing fixtures used by patients/residents shall be between one hundred five degrees (105F) and one hundred twenty degrees (120F) Fahrenheit.<br>This Rule is not met as evidenced by:<br>Please refer to F-323 as it refers to water temperatures. | C 445         | See F Tag 323   | 9/16/13            |
| C 644              | 02.150,01,a,i Handwashing Techniques<br><br>a. Methods of maintaining sanitary conditions in the facility such as:<br><br>i. Handwashing techniques.<br>This Rule is not met as evidenced by:<br>Please refer to F441 as it relates to infection control and handwashing.   | C 644         | See F Tag 441   | 9/16/13            |
| C 703              | 02.152,03,a,i Idaho Licensed Social Worker  | C 703         |   | 9/16/13            |

Bureau of Facility Standards

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>MDS001820</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>08/16/2013</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>VALLEY VISTA CARE CTR OF ST MARIES</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>820 ELM STREET<br/>ST MARIES, ID 83861</b> |
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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 703              | Continued From page 2<br><br>i. Is a social worker licensed by the state of Idaho as a social worker or who receives regular consultation from such a qualified social worker. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility did not provide adequate services or consultation from a licensed social worker. This was true for 13 of 13 sampled residents residing in the facility and had the potential to effect all residents residing in the facility.<br><br>On 8/13/13 at 4:30 PM, the Social Services Designee (SSD) was interviewed regarding the psychosocial needs of the residents. The SSD was not a Licensed Social Worker (LSW). The SSD said the LSW would come to the facility every 6 months and review charts of residents with concerns. When asked what happens if she had questions or when a crisis arises in the facility in between visits, she said she could contact the LSW via email for questions. | C 703         | <b>1. The facility's LSW Justin Smiley made a routine visit to the St. Maries building for review of its behavioral program and social service needs on 9/12/13. He was last in the building on 4/26/13.</b><br><br><b>2. All residents with social service needs have the potential to be affected.</b><br><br><b>3. A quarterly schedule was been established on 9/12/13 for routine social service reviews. He was a part time employee and will become full time effective 10/15/13.</b><br><br><b>4. This area will be reviewed by the Administrator and reported in QA quarterly for proper compliance.</b> | 9/16/13            |
| 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; This Rule is not met as evidenced by: Refer to F 280 as it relates to revising care plans.   | C 782         | See F Tag 280   | 9/16/13            |
| C 784              | 02.200,03,b Resident Needs Identified<br><br>b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident   | C 784         | See F Tag 309   | 9/16/13            |

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| C 784              | Continued From page 3<br><br>receives care necessary to meet his total needs. Care shall include, but is not limited to:<br>This Rule is not met as evidenced by:<br>Please refer to F309 as it relates Highest Practical Care:  | C 784         |   |                    |
| C 787              | 02.200,03,b,iii Fluid/Nutritional Intake<br><br>iii. Adequate fluid and nutritional intake, including provisions for self-help eating devices as needed;<br>This Rule is not met as evidenced by:<br>Please refer to F309 as it relates to assisting a resident to eat.  | C 787         | See F Tag 309   | 9/16/13            |
| 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 F314 regarding pressure sores acquired while in the facility. | C 789         | See F Tag 314   | 9/16/13            |
| C 790              | 02.200,03,b,vi Protection from Injury/Accidents<br><br>vi. Protection from accident or injury;<br>This Rule is not met as evidenced by:<br>Please refer to F323 as it relates to accidents and falls.  | C 790         | See F Tag 323   | 9/16/13            |

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| C 795              | Continued From page 4   | C 795         |   |                    |
| 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;<br>This Rule is not met as evidenced by:<br>Please refer to F315 as it relates to bowel, bladder, and UTI's. | C 795         | See F Tag 315   | 9/16/13            |