



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7012 1010 0002 0836 2106

October 25, 2013

Josiah C. Dahlstrom, Administrator
Monte Vista Hills Healthcare Center
1071 Renee Avenue
Pocatello, ID 83201-2508

Provider #: 135018

Dear Mr. Dahlstrom:

On **October 10, 2013**, we conducted an on-site follow-up revisit to verify that your facility had achieved and maintained compliance. We had presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **August 21, 2013**. However, based on our on-site follow-up revisit conducted **October 10, 2013**, we found that your facility is not in substantial compliance with the following participation requirements:

F431 -- S/S: D -- 42 CFR §483.60(b), (d), (e) -- Drug Records, Label/Store Drugs & Biologicals

F514 -- S/S: E -- 42 CFR §483.75(l)(1) -- Resident Records-Complete/Accurate/Accessible

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare/Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each federal and state tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance.** After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 7, 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.

- The administrator must sign and date the first page of both the federal survey report, Form

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

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

As noted in the letter of **July 15, 2013**, following the **Recertification, Complaint Investigation and State Licensure** survey of **June 21, 2013**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **December 21, 2013**, 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.

STATE ACTIONS effective with the date of this letter (**October 25, 2013**): None

If you believe the 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.

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

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

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

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process

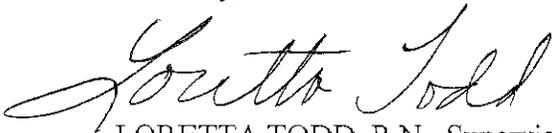
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2001-10 IDR Request Form

This request must be received by **November 7, 2013**. If your request for informal dispute resolution is received after **November 7, 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 on-site follow-up revisit. If you have any questions or concerns, please contact this office at (208) 334-6626.

Sincerely,

A handwritten signature in cursive script that reads "Loretta Todd".

LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj
Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135018	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 10/10/2013
NAME OF PROVIDER OR SUPPLIER MONTE VISTA HILLS HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVENUE POCATELLO, ID	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
{F 281}	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure 1 of 2 licensed nurses (LNs) did not pre-initial medications as administered before they actually administered the medications. This affected 1 of 8 residents (#18) during medication pass observations. This failure created the potential for unrelieved pain if the hydrocodone tablet (relieves moderate to severe pain) for Resident #18 had not been administered. Findings included:</p> <p>Note: Informational Letter #97-3, dated April 16, 1997: The Medication Distribution Technique Clarification To Informational Letter, 96-14, from the Bureau of Facility Standards, stated, "The issue arose when the Board of Nursing received information that long term care facility staff were signing medications as given at the time of the medication preparation, not after the resident actually received the medication. ...the Board's expectation, and the accepted standard of practice, is that licensed nurses document those things they have done, not what they intend to do."</p> <p>On 10/9/13 at 4:10 p.m., LN #1 was observed as he removed one hydrocodone tablet from the bubble pouch for Resident #18 and placed it in a medicine cup. The LN debated initialing the medication as administered on the Medication Administration Record (MAR) prior to administration and stated, "With PRN [as needed] meds [medication] I sign first because I have to record the time. That's how I've been doing it," and initialed the hydrocodone as administered. LN #1 then went into Resident #18's room and administered the medication.</p> <p>On 10/10/13 at 11:20 a.m., the Administrator and DON were informed of the pre-initialing medication prior to administration. However, no further information or documentation was provided that resolved the issue.</p>		

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

The above isolated deficiencies pose no actual harm to the residents

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

PRINTED: 11/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 10/10/2013
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NAME OF PROVIDER OR SUPPLIER MONTE VISTA HILLS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVENUE POCATELLO, ID 83201
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{F 000}	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the followup recertification and complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were: Arnold Rosling RN, BSN, QMRP Team Coordinator Karen Marshall, RD Brad Perry, BSW, LSW Lauren Hoard, RN</p> <p style="text-align: center;">RECEIVED NOV - 8 2013</p> <p>Survey Definitions: FACILITY STANDARDS MDS = Minimum Data Set CAA = Care Area Assessment CMS = Centers for Medicare & Medicaid Services CNA = Certified Nurse Aide DNS/DON = Director Nursing Services/Director of Nursing</p>	{F 000}	<p>The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s).</p>	
{F 431} SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p>	{F 431}	<p>F431</p> <p>A. Corrective Actions: A medication error report was filled out for this incident and the error noted was identified by the DNS and corrected in her writing. A new label was also obtained from the pharmacy and placed on the medication card.</p> <p>B. Identification of others affected and corrective actions: Any resident with a mismatched medication label could have been affected. The pharmacy was made aware of the concern and DNS/LN designee has conducted an audit to ensure all potential concerns regarding medication labels not matching orders would be addressed immediately. Training with the nurses inputting all medications has also been conducted to ensure that all nurses inputting orders in the resident's record are able to do it</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Gezrah Duhstrow* TITLE: *Executive Director* (X6) DATE: *11/7/13*

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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NAME OF PROVIDER OR SUPPLIER MONTE VISTA HILLS HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVENUE POCATELLO, ID 83201		
(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 431}	<p>Continued From page 1</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of physician orders, it was determined the facility failed to ensure medication labels matched the physician orders. This affected 1 of 8 residents (#18) during medication pass observations. The mislabeled medication had the potential for unrelieved pain should the resident not receive the allotted dosage of hydrocodone (relieves moderate to severe pain). Findings include: On 10/9/13 at 4:10 p.m., LN #1 was observed dispensing medication for Random Resident #18, from a bubble pack card. The label on the bubble pack card read, "Take 1 tablet by mouth every four hours as needed, Hydroco[done]/APAP [Acetaminophen] 10-325 Tabs [tablets]" and had initials on the bottom of the label in black ink.</p>	{F 431}	<p>correctly to ensure the order is sent to the pharmacy to be filled and labeled appropriately. The pharmacy has also conducted an audit of all residents to double check and ensure no further concerns exist. The nurses will also sign in all medications by comparing them to the MAR and ensure that all labels match the MAR (current physician's order) correctly.</p> <p>C. Measures to ensure that the deficient practice does not happen again: In addition to "B" above, Medical Records will print out a report of all new orders daily (M-F) and provide to the DNS/LN designee for review to ensure ongoing compliance and any concerns will be addressed immediately and discussed with the QA committee. This audit will begin 10/22/13</p> <p>D. Monitor corrective actions: The audits will be performed daily on residents with new orders for 4 weeks, weekly times 4 weeks, and every other week times 4 weeks. Results of the audits will be reported to the QA committee monthly who can adjust the frequency of monitoring as it deems necessary to ensure ongoing compliance.</p> <p>E. Corrective actions will be completed:</p>	10/22/13

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{F 431}	<p>Continued From page 2</p> <p>The Medication Administration Record (MAR), order date of 6/9/11, for Random Resident #18 documented in part: Norco (Hydrocodone-Acetaminophen) 10-325 mg [milligrams] By mouth (PO) - PRN, : Take 1-2 tabs [tablets] every 4 hours.</p> <p>Resident #18's All Active Orders for September 2013 (recapitulation orders) documented in part: * Norco (Hydrocodone-Acetaminophen) 10-325 MG By mouth (PO) - PRN, : Take 1-2 tabs [tablets] every 4 hours.</p> <p>On 10/9/13 at 4:15 p.m., LN #1 was asked if he saw a problem with the label on the bubble pack card and the order on the MAR. The LN stated, "Yeah. We'll have to call pharmacy and get that label changed."</p> <p>On 10/10/13 at 8:30 a.m., the Norco bubble pack card for Random Resident #18 was observed to have new writing in black ink on the label that documented, "Take 1-2 q [every] 4 hours PRN."</p> <p>On 10/10/13 at 9:00 a.m., the DON was asked whose initials were on the bottom of the label on the Norco bubble pack card written in ink. She said the initials belonged to the pharmacist. The DON was then asked when the information in ink was written on the label and she replied, "I wrote that yesterday after your med pass with the nurse and called pharmacy." The DON added that the pharmacist would be coming in later that day to change the label. When asked if she acknowledged that the typed label on the Norco bubble pack card was incorrect, the DON said, "Yeah."</p> <p>On 10/10/13 at 11:20 a.m., the Administrator and</p>	{F 431}		

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{F 431}	Continued From page 3 DON were informed of the inaccurate labeling issue. However, no further information or documentation was provided that resolved the issue.	{F 431}		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 10/10/2013
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NAME OF PROVIDER OR SUPPLIER MONTE VISTA HILLS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVENUE POCATELLO, ID 83201
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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 followup state and complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were: Arnold Rosling RN, BSN, QMRP Team Coordinator Karen Marshall, RD Brad Perry, LSW Lauren Hoard, RN</p>	{C 000}	<p>The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s).</p>	
{C 745}	<p>02.200,01,c Develop/Maintain Goals/Objectives</p> <p>c. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Refer to F281 as it relates to initialing medications as administered prior to administration.</p>	{C 745}	<p>C 745 Cited at a scope and severity of "A" and does not require a written plan of correction.</p> <p>C 830 Please refer to the response to F431.</p>	
C 830	<p>02.201,02,d Nursing Prohibited from Packing/Repacking</p> <p>d. Nursing service personnel shall not package or repackage, bottle or label any medication, in whole or in part.</p> <p>This Rule is not met as evidenced by: Refer to F431 as it relates to nursing staff</p>	C 830	<p>C 832 Please refer to the response to F431.</p> <p style="text-align: right;">RECEIVED NOV - 8 2013 FACILITY STANDARDS</p>	

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Joseph Dahlstrom</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>11/7/13</i>
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Bureau of Facility Standards

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C 830	Continued From page 1 relabeling medications.	C 830		
{C 832}	<p>02.201,02,f Labeling of Medications/Containers</p> <p>f. All medications shall be labeled with the original prescription legend including the name and address of the pharmacy, patient's/resident's name, physician's name, prescription number, original date and refill date, dosage unit, number of dosage units, and instructions for use and drug name. (Exception: See Unit Dose System.)</p> <p>This Rule is not met as evidenced by: Refer to F431 as it relates to inaccurate medication labeling.</p>	{C 832}		

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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiency was cited during the complaint investigation survey of your facility. The team entered on 10/8/2013 and exited on 10/10/13.</p> <p>The surveyors conducting the survey were: Arnold Rosling RN, BSN, QMRP Team Coordinator Karen Marshall, RD Brad Perry, BSW, LSW Lauren Hoard, RN</p> <p>Survey Definitions: MDS = Minimum Data Set CAA = Care Area Assessment CMS = Centers for Medicare & Medicaid Services CNA = Certified Nurse Aide DNS/DON = Director Nursing Services/Director of Nursing</p> <p>F 514 SS=E 483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p>	F 000	<p>The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s).</p> <p>F514 A. Corrective Actions: There were no evidence of draft notes found in any of the clinical records for the residents either prior to or during the survey inspection. The ability to draft progress notes has been removed from the electronic record and is no longer an option. B. Identification of others affected and corrective actions: No residents were affected by this citation but there was a potential to affect all residents in the facility. Prior to and after the survey inspection the facility DNS and administrator have audited daily the resident electronic medical record to ensure there were no draft notes older than 24 hours. As of 10/30/2013, the Ensign Group central office made the decision to remove the ability to document draft progress notes from all SNF's that</p>	
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RECEIVED
NOV - 8 2013
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Joshua Dahlstrom</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>11/7/13</i>
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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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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/10/2013
NAME OF PROVIDER OR SUPPLIER MONTE VISTA HILLS HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVENUE POCATELLO, ID 83201		
(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 514	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on a complaint from the public and staff interview, the facility failed to ensure that accepted professional standards were followed related to making entries in residents' electronic medical records (EMR). Modifications to resident records without documented evidence of those modifications had the potential to affect any resident in the facility including 6 of 6 sampled residents (#s 1, 3, 11, 20, 21 and 24). Findings include:</p> <p>The interpretive guidance at F 514 documents the following as it relates to computer progress notes:</p> <p>"In cases in which facilities have created the option for an individual's record to be maintained by computer, rather than hard copy, electronic signatures are acceptable. In cases when such attestation is done on computer records, safeguards to prevent unauthorized access, and reconstruction of information must be in place. The following guideline is an example of how such a system may be set up:</p> <ul style="list-style-type: none"> o There is a written policy, at the health care facility, describing the attestation policy(ies) in force at the facility. o The computer has built-in safeguards to minimize the possibility of fraud. o Each person responsible for an attestation has an individualized identifier. o The date and time is recorded from the computer's internal clock at the time of entry. o An entry is not to be changed after it has been recorded. o The computer program controls what sections/areas any individual can access or enter 	F 514	<p>previously had that functionality. Because this option has been removed, we do not have the ability to save a progress note as a draft as we could previously do.</p> <p>C. Measures to ensure that the deficient practice does not happen again: The facility DNS and Administrator have checked the Point Click Care dashboard each day upon exit of the survey to ensure there were no draft progress notes. As the ability to save progress notes as a draft has been removed from the Point Click Care system within our facility the possibility for this deficient practice to reoccur under our current circumstance does not exist.</p> <p>D. Monitor corrective actions: The DNS and/or ED will audit Point Click Care daily for the use of draft notes. These audits will continue for 1 month to verify that the functionality has been removed from all users to save draft progress notes. The QI committee will meet in November to discuss compliance with this citation and discuss the need for further monitoring beyond the 30 days after survey exit as the system has been updated to remove the ability to save draft progress notes from all who have access at this location.</p> <p>E. Corrective actions will be completed:</p>	10/22/13

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

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F 514	<p>Continued From page 2</p> <p>data, based on the individual's personal identifier (and, therefore, his/her level of professional qualifications)."</p> <p>The Bureau of Facility Standards received a complaint that the DON and Staff Development Coordinator (SDC) had instructed staff to document their progress notes in a "draft format." The DON or SDC would review the staff's notes, approve them or make recommendations to change them. The staff were to make the necessary changes and finalize the notes to make them permanent.</p> <p>On 10/9/13 at 3:15 p.m. the SDC was interviewed about documentation in the electronic medical record. The SDC indicated staff had two inservices about electronic documentation. She did daily review of nursing progress notes with all licensed nurses. Staff had been instructed to document and save the documentation as a "Draft." Then it would be reviewed and suggestions for changes were made, staff would then make the changes and save it to a permanent copy. The nurses were to finish charting before they finished their shift.</p> <p>On 10/09/13 at 3:30 p.m. the DON was interviewed. The corporate consultant was present in the room during the interview. The DON provided the same information as the SDC. In addition, she stated the draft was password protected and only the original author could make additions and changes. Staff were required to finish their notes before leaving the facility.</p> <p>Information about what the staff did if the SDC or DON were not available to review their documentation was not resolved during the</p>	F 514			

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F 514	Continued From page 3 interview. The SDC and DON did not provide the information other than nursing documentation needed to be completed by the end of the nurses scheduled shift. The question was asked several times about nurses writing in "Draft" format then leaving at the end of the day/shift. Their response was always that the nurse would be called back to finalize the document. They did not address why the staff did not write in finalized format originally or what staff were to do if there was no supervisor to review the nursing documentation, such as during the weekend. The Administrator and DON were informed about the documentation issues on 10/10/13 at 11:15 a.m. No further information was provided.	F 514			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/10/2013
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NAME OF PROVIDER OR SUPPLIER MONTE VISTA HILLS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVENUE POCATELLO, ID 83201
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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 deficiency was cited during the complaint investigation survey of your facility. The team entered on 10/8/2013 and exited on 10/10/13.</p> <p>The surveyors conducting the survey were: Arnold Rosling RN, BSN, QMRP Team Coordinator Karen Marshall, RD Brad Perry, LSW Lauren Hoard, RN</p>	C 000	<p>The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s).</p> <p>C 879 Please refer to the response to F514.</p>	
C 879	<p>02.203 PATIENT/RESIDENT RECORDS</p> <p>203. PATIENT/RESIDENT RECORDS. The facility maintains medical records for all patients/residents in accordance with accepted professional standards and practices. This Rule is not met as evidenced by: Refer to F 514 as it relates to medical record professional standards.</p>	C 879	<p>RECEIVED NOV - 8 2013 FACILITY STANDARDS</p>	

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Josiah Dahlstrom</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>11/7/13</i>
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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

November 15, 2013

Josiah C. Dahlstrom, Administrator
Monte Vista Hills Healthcare Center
1071 Renee Avenue
Pocatello, ID 83201-2508

Provider #: 135018

Dear Mr. Dahlstrom:

On **October 10, 2013**, a Complaint Investigation survey was conducted at Monte Vista Hills Healthcare Center. Arnold Rosling, R.N., Q.M.R.P., Karen Marshall, R.D., Bradley Perry, L.S.W. and Lauren Hoard, R.N. conducted the complaint investigation.

The complaint was investigated by using observations and interviews with the maintenance man and Administrator.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006104

ALLEGATION #1:

The facility has no air conditioning. It is extremely hot in the building. They have some swamp coolers. The special care unit is especially hot.

FINDINGS:

The maintenance man was interviewed on October 8, 2013, at 4:15 p.m. According to the maintenance man, the facility at the time of the complaint investigation was in the process of installing "PTAC" units. These units were both heaters and air conditioners. The units were being installed in every resident's room, offices and common areas. There were 63 units

Josiah C. Dahlstrom, Administrator
November 15, 2013
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purchased in all. At the time of the interview, the electrician had 17 units left to install. The facility was removing the swamp coolers and fixing the holes in the roof left by the removal.

On October 9, 2013, at 5:00 p.m., the Administrator was asked why the facility decided to take out the swamp coolers and put in the PTAC units. He indicated that the three swamp coolers were breaking down all the time. He said that they made a decision right after the corporation took over the building to replace the coolers, but because of the cost being over \$100,000 the facility had to wait until it could be budgeted. It is now budgeted and they are in the process to get the units installed and take out the radiators and swamp coolers.

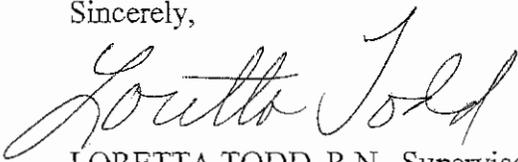
The Administrator said the facility originally purchased 15 air conditioners and placed them strategically in rooms around the facility to compensate for the poor functioning swamp coolers.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaint's allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in cursive script that reads "Loretta Todd".

LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
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November 15, 2013

Josiah C. Dahlstrom, Administrator
Monte Vista Hills Healthcare Center
1071 Renee Avenue
Pocatello, ID 83201-2508

Provider #: 135018

Dear Mr. Dahlstrom:

On **October 10, 2013**, a Complaint Investigation survey was conducted at Monte Vista Hills Healthcare Center. Arnold Rosling, R.N., Q.M.R.P., Karen Marshall, R.D. Bradley Perry, L.S.W. and Lauren Hoard, R.N. conducted the complaint investigation. The complaint was investigated in conjunction with a follow up survey and two other complaints.

The following documents were reviewed:

- The entire medical record of the identified resident; and
- Adaptive equipment for eating for the identified resident and three other residents;

Two meal observations were conducted during the survey.

Interviews were conducted with residents, Director of Nursing and Director of Therapy.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006207

ALLEGATION #1:

The complainant stated that a named resident had died from not getting enough to eat. The complainant indicated that several weeks prior to the named resident's death, adaptive equipment was not provided for the resident; the resident did not receive help from staff and often left the table without eating. The complainant named current resident(s) who had witnessed this lack of care and were interviewable.

Josiah C. Dahlstrom, Administrator
November 15, 2013
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FINDINGS:

The identified resident was deceased. The resident's closed record was reviewed. The resident's discharge summary documented the resident did not die of starvation. The resident's occupational therapy progress report addressed the need for adaptive eating equipment. The therapy report documented different adaptive equipment was tried by the resident to determine which devices worked best for the resident. Weight records for the last six months of the resident's life documented weight gain and not weight loss. Meal monitors for the resident's last month of life documented the resident ate ninety to one hundred percent of meals.

During the meal observations, three other residents were observed to have adaptive equipment as directed by their therapy and care plans. Staff was observed assisting all residents in the two dining rooms that needed help eating.

During an interview with a named witness resident, the resident stated s/he did not have a concern about any specific resident. The witnessing resident described himself/herself as sensitive and did not like seeing people struggling to eat with adaptive equipment. The resident did not think anyone had died due to lack of nutrition or eating assistance at the facility.

The Director of Nursing was interviewed regarding meal monitor documentation who said if there is a concern about weight loss, she gets the Dietary Manager and the Registered Dietitian involved in developing a plan to address the issue. The Director of Therapy was interviewed regarding the use of adaptive equipment for residents during meals. She said the therapy staff had tried several different adaptive devices for the resident in question in order to improve the resident's eating ability. She said the equipment had worked and the resident had been able to meet his goals successfully.

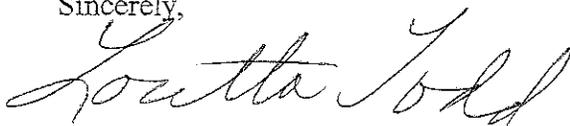
Based on records reviewed, observations and interviews, it was determined the facility was in compliance with Federal guidelines.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaint's allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj



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November 15, 2013

Josiah C. Dahlstrom, Administrator
Monte Vista Hills Healthcare Center
1071 Renee Avenue
Pocatello, ID 83201-2508

Provider #: 135018

Dear Mr. Dahlstrom:

On **October 10, 2013**, a Complaint Investigation survey was conducted at Monte Vista Hills Healthcare Center. Arnold Rosling, R.N., Q.M.R.P., Karen Marshall, R.D., Bradley Perry, L.S.W. and Lauren Hoard, R.N. conducted the complaint investigation.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006229

ALLEGATION #1:

Complainant stated the new Director of Nursing (DoN) requires all nurses to write progress notes in "draft." The DoN or the Staff Development Coordinator then reviews the draft information and will tell the nurse/writer there is too much information and to take things out. This started about a month ago. The complainant stated that any nurse would confirm the above.

FINDINGS:

This complaint was investigated during the follow-up survey. The SDC and DoN were interviewed about the allegations.

The SDC and DoN confirmed during an interview that staff had been instructed to document in

Josiah C. Dahlstrom, Administrator
November 15, 2013
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"Draft" format. The facility was cited at F514, Medical Records.

CONCLUSIONS:

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

ALLEGATION #2:

The complainant alleged that somewhere between August 1, 2013 and September 30, 2013, two nursing assistants on night shift raised a named resident's bed to provide cares. The CNAs forgot to lower the bed and the resident fell out of bed. The resident has a history of falling out of bed. The CNAs thought the resident fell out of bed about midnight. The next morning the resident had pain and swelling in her ankle. The resident is on hospice so an x-ray was not done, but there is a probable fracture of the left ankle.

The resident's physician is also the medical director of the Alliance hospice agency. The physician saw the resident after he was notified of pain and swelling. The investigation concluded the resident used the controls and raised the bed. The complainant stated the resident is not capable of raising the bed.

The CNAs felt bad and stated the bed controls were attached to the head of the bed and they thought they forgot to lower the bed. The complainant thinks the facility is covering up the incident.

FINDINGS:

The facility's investigation of the incident was reviewed. The resident's medical record did not support all the allegations the complainant made about the incident that occurred.

The Medical Record Progress notes document the resident fell at 10:30 p.m. on August 17, 2013. The note further documented, the bed was "up as far as it would go," and the resident had no noted injuries and no complaints of pain. The resident was returned to her bed at that time. The next progress note was August 18, 2013, at 4:07 a.m., and it did not address the resident's fall or if she was having pain. The next progress note was August 18, 2013, at 2:48 p.m. The hospice aide brought the change she noted in the resident's right ankle to the nurse's attention. The ankle was "swollen and bruising." The resident's hospice physician was in the facility at that time, the ankle was evaluated and an immobilizer was ordered to be used for three months.

The Incident and Accident report documented the resident had an un-witnessed fall on August 17, 2013, at 10:30 p.m. The resident was heard "calling for help" and staff responded and found her on the floor. The resident was placed back into bed, and the bed controls were placed at the

Josiah C. Dahlstrom, Administrator
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head of the bed. The investigation completed on August 19, 2013, at 2:30 p.m. by the Administrator and DoN found evidence that the resident was able to raise the position of the bed. The resident did not remember what happened and did not fully understand the bed controls but was able to make the bed rise by pushing the buttons. The resident had soiled herself and was possibly trying to get to the bathroom when the fall occurred.

The Administrator was interviewed on October 10, 2013, at 8:50 a.m. He was instrumental with testing the resident in the use of the bed controls. He said the resident was able to raise the bed but really was not cognitively aware of what she was doing. The resident did not lower the bed and appeared confused when asked to do so, she just kept pushing the buttons.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in cursive script that reads "Loretta Todd".

LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj