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 3050 0001 2125 6010**

November 7, 2014

Bradley M. Hruza, Administrator
Valley Vista Care Center of St Maries
820 Elm Street
St Maries, ID 83861-2119

FILE COPY

Provider #: 135075

Dear Mr. Hruza:

On **October 24, 2014**, a Recertification and State Licensure survey was conducted at Valley Vista Care Center of St Maries by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE**: The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 20, 2014**. Failure to submit an acceptable PoC by **November 20, 2014**, may result in the imposition of civil monetary penalties by **December 10, 2014**.

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

  If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

> **Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 24, 2015**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid**

**Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

- BFS Letters (06/30/11)

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

This request must be received by **November 20, 2014**. If your request for informal dispute resolution is received after **November 20, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

Lorene Kayser

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

AH
"A" FORM

| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # 135075 | MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | DATE SURVEY COMPLETE: 10/24/2014 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES | STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID | | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
|---|---|
| F 281 | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, it was determined the facility failed to ensure professional standards of quality were maintained. This was true for 1 of 10 residents (#2) observed during the medication pass. Findings included:<br><br>Informational Letter #97-3, dated April 16, 1997: The Medication Distribution Technique Clarification To Informational Letter, 96-14, from the Bureau of Facility Standards, states, "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."<br><br>Resident #2 was readmitted to the facility on 9/20/14 with multiple diagnoses which included multiple sclerosis (MS) and paraplegia.<br><br>On 10/22/14 at 11:30 AM, LN #2 was observed to administer the following medications to Resident #2:<br>*Baclofen 15 mg;<br>*Neurontin 800 mg; and,<br>*Methadone 5 mg.<br><br>After giving the medications, LN #2 was not observed to stop at the medication cart to initial the medications as given. Instead, LN #2 was observed to go to the Atrium to check with another resident on the effectiveness of a pain medication given earlier.<br><br>On 10/22/14 at 11:45 AM, the surveyor asked LN #2 if she was going to initial the aforementioned medications given to Resident #2. LN #2 stated, "I did initial the medications," and showed the resident's MAR to the surveyor which documented the medications had been initialed. The surveyor informed LN #2 the medications had not been observed to be initialed after the medications were given and had been initialed prior to administration.<br><br>On 10/23/14 at 3:45 PM, the Administrator and DON were made aware of the medication pass observation. No further information was provided by the facility. |

RECEIVED
NOV 23 2014
FACILITY STANDARDS

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

RECEIVED
NOV 20 2014
FACILITY SERVICES

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

PRINTED: 11/05/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135075 | | 10/24/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VALLEY VISTA CARE CENTER OF ST MARIES | 820 ELM STREET<br>ST MARIES, ID 83861 |

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|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>The following deficiencies were cited during the annual federal recertification survey of your facility.<br><br>The surveyors conducting the survey were:<br>Brad Perry, BSW, LSW, Team Coordinator<br>Lauren Hoard RN, BSN<br>Rebecca Thomas, RN<br><br>The survey team entered the facility on October 20, 2014 and exited on October 24, 2014.<br><br>Survey Definitions:<br>ADL = Activities of Daily Living<br>BID = Two Times a Day<br>BIMS = Brief Interview for Mental Status<br>CNA = Certified Nurse Aide<br>CPAP = Continuous Positive Airway Pressure<br>DON = Director of Nursing<br>GM = Gram<br>HS = Before Sleep, At Bedtime<br>IM = Intramuscular<br>LN = Licensed Nurse<br>MAR = Medication Administration Record<br>MDS = Minimum Data Set assessment<br>MG = Milligram<br>PCP = Primary Care Provider<br>PO = By Mouth<br>PRN = As Needed<br>TAR = Treatment Administration Record<br>TID = Three Times a Day | F 000 | This Plan of Correction does not constitute an admission or agreement by the provider of the truth if 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 law require it. This provider maintains 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.<br><br>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 | |
| F 164<br>SS=D | 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS<br><br>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. | F 164 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11/19/14

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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| | 135075 | | 10/24/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 164 | Continued From page 1<br><br>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.<br><br>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.<br><br>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.<br><br>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, it was determined the facility failed to protect a resident's personal medical information during the survey process. This was true for one random resident (#16) sampled for confidentiality of records. This failed practice created the potential to negatively affect the resident's psychosocial well-being related to the need for privacy.<br>Findings included:<br><br>Resident #16 was admitted to the facility on | F 164 | chronologically to the date the provider is under the opinion it was in compliance with requirements of participation or that corrective action was necessary.<br><br>1. Resident #16 Controlled Drug Record was closed on 10/20/14 and no longer visible on the med cart.<br>2. All residents have the potential to be affected. The ADNS rounded during AM and PM med pass on 11/14/14 and found no additional privacy issues related to the controlled drug record or med pass.<br>3. In servicing was held on 10/28/14 and 10/30/14 for HIPPA compliance and the importance of protecting resident information.<br>Daily rounds are to be conducted by the DNS or designee to monitor compliance with patient privacy/confidentiality of records for one month | 11/17/14 |

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| F 164 | Continued From page 2<br>5/24/11 with multiple diagnoses which included DJD (degenerative joint disease), osteoarthritis of lumbar spine, and chronic pain syndrome.<br><br>On 10/20/14 at 1:55 PM, the surveyor observed a Controlled Drug Record for the resident with the medication Fentanyl 25 mcg/hr patch exposed on top of the South Medication Cart. The medication cart was unattended and parked at the East Nurse's Station. The Controlled Drug Record contained the resident's name, room number, medication, dosage directions and name of physician.<br><br>On 10/20/14 at 2:10 PM, LN #1 returned to the South Medication Cart and was interviewed in regard to the Controlled Drug Record. When asked if it should have been left out for anyone who might walk by to see, LN #1 stated, "No, it should not."<br><br>HIPAA references the Health Insurance Portability and Accountability Act, a Federal law which gives patient's rights over their health information and sets rules and limits on who can look at and receive patient's health information. The Privacy Rule applies to all forms of individuals' protected health information, whether electronic, written, or oral. (Reference: U.S. Department of Health & Human Services, Understanding Health Information Privacy, http://www.hhs.gov/ocr/privacy/hipaa/administrative/index.html)<br>On 10/22/14 at 5:50 PM, the Administrator and the DON were informed of the concern with confidentiality of records. No further information was provided by the facility. | F 164 | beginning on 11/14/14, followed by weekly rounds for two months.<br>4. DNS or designee will report findings in Monthly QA starting 11/14/14 for three months at which time QA committee will determine ongoing frequency. | |
| F 278 | 483.20(g) - (j) ASSESSMENT | F 278 | | |

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| F 278<br>SS=D | Continued From page 3<br>ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, it was determined the facility failed to ensure MDS assessments were accurate. This was true for 1 of 13 (#4) sampled residents when the quarterly MDS assessment did not code the resident received antipsychotic medication. Inaccurate | F 278 | 1. Resident #4's MDS assessment was revised by MDS coordinator to reflect the antipsychotic medication use on 11/13/14.<br>2. All residents with antipsychotic medications have the potential to be affected by this MDS coding errors. An MDS review of this item (N0410A) was conducted starting on 10/23/14 and ongoing by the MDS coordinator to ensure that all of these residents last MDS was coded correctly.<br>3. The MDS coordinators reviewed section N0410A of the RAI manual on 11-07-14 and will be more diligent in reviewing the MARS during the look back period in the future. MDS correction to section N was completed on 11/13/14. Starting 11/13/14, the DNS or designee will randomly audit section N0410A monthly to ensure proper coding of residents on antipsychotic meds. | 11/17/14 |

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| F 278 | Continued From page 4<br>assessments can lead to potential harm when the area that was inaccurate did not trigger a potential problem for further assessment and care planning. Findings included:<br><br>Resident #4 was admitted to the facility on 3/14/11 with multiple diagnoses which included dementia with behavioral disturbance and psychosis.<br><br>The 5/9/14 quarterly MDS assessment Section N for "Medications" did not document Resident #4 received antipsychotic medication.<br><br>A Psychoactive Medication History report documented Resident #4 had an order for, "Seroquel 25 mg PO Q [Every] hs x 2 weeks then increase to 50 mg Q HS," dated 1/24/14.<br><br>Resident #4's October 2014 recapitulated Physician's Orders documented the order, "SEROQUEL 50mg PO Q HS - PSYCHOSIS," with a date of 2/6/14.<br><br>On 10/22/14 at 10:45 a.m., the Behavior Unit Program Manager said Resident #4 had received Seroquel daily since January 2014.<br><br>On 10/22/14 at 2:12 p.m., the MDS nurse was asked about the MDS assessment for Resident #4 and stated, "It probably just got missed."<br><br>On 10/22/14 at 5:50 p.m., the Administrator and DON were informed of the inaccurate MDS assessment. No further information or documentation was provided. | F 278 | 4. The DNS or designee will follow this issue in QA review and report to the QA committee monthly for three months beginning at the next QA scheduled for 11/17/14. After three months the QA committee will determine the ongoing auditing frequency. Increased consultant audits have been added for additional support from biannually to three times per year. | |
| F 279<br>SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS | F 279 | | |

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| F 279 | Continued From page 5<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, it was determined the facility failed to develop a care plan which had been initiated for the problem of CPAP (Continuous Positive Airway Pressure) Cleaning/Care/Maintenance Instructions. This was true for 1 of 9 (#8) sampled residents. A lack of instruction to staff regarding the care of, cleanliness and maintenance of the CPAP device created the potential for the resident's respiratory condition to worsen and to experience increased sleepiness and lethargy. Findings included:<br><br>Resident #8 was admitted to the facility on | F 279 | 1. Resident #8's care plan was completed on 10/23/14.<br>2. All residents have the potential to be affected. Through admit assessment, quarterly MDS review, prn change of status review and weekly chart audit reviews residents will be identified for care plan updates.<br>3. In servicing was held on 11/4/14 on care plan completion and accuracy and will be ongoing. Weekly chart audit reviews were initiated on 10/28/14.<br>4. The DNS or designee will follow this issue in QA review and report to the QA committee monthly. Resident chart review will be performed weekly for three months by our interdisciplinary team beginning 11/11/14. After three months the QA committee will determine the ongoing auditing frequency. | 11/17/14 |

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| F 279 | Continued From page 6<br>11/15/06 and readmitted on 5/10/10 with multiple diagnoses which included chronic obstructive pulmonary disease (COPD), chronic respiratory failure and obstructive sleep apnea.<br><br>Record review documented a care plan for the problem of Impaired Gas Exchange had been developed with an origin date of 11/15/06 related to COPD/Chronic Respiratory Failure/Morbid Obesity. An intervention documented to, "Ensure routine care/cleaning/maintenance of CPAP machine as per CPAP Care Plan and and ADL (Activities of Daily Living) Care Plan."<br><br>Record review of the problem CPAP Cleaning/Care/Maintenance Instructions with an origin date of 3/2/11 documented only the problem name. The care plan contained a blank sheet without documentation in the Related To section, Exhibited By section and Goal section and did not document interventions.<br><br>On 10/23/14 at 10:15 AM, the DON was shown the CPAP Cleaning/Care/ Maintenance Instructions Care Plan and stated, "Looks blank to me, no information of care and cleaning." The DON stated, "We do have information of care and cleaning in front of the ADL Care Plan the CNA's use and I will get a copy of that for you." When asked if that information should have been included in the CPAP Cleaning/Care/Maintenance Instructions Care Plan, the DON stated, "Yes, it should."<br><br>NOTE: The ADL Care Plan is not part of the care plan located in the resident's chart but is a synopsis of the care plan which the CNA's use for direction of care. | F 279 | | |

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| F 279 | Continued From page 7<br>On 10/22/14 at 5:50 PM, the Administrator and the DON were made aware of the concerns regarding care plans. No further information was received from the facility. | F 279 | | |
| F 280<br>SS=E | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, 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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interview, it was determined the facility failed to revise care plans for 4 of 13 sample residents (#s 1, 4, 6, & 8). The care plans:<br>*contained information related to oxygen, but was no longer in use;<br>*documented a resident was on the secured unit, | F 280 | 1. Resident #1's comprehensive care plan was updated immediately on 10/22/14 to reflect her current level of care. Resident #2's care plan was updated on 10/22/14 to reflect her care level in the non-secure behavioral unit. Resident #4's Self Care Deficit Care Plan, Incontinence Care Plan and ADL Care Plan were all updated immediately on 10/23/14 to reflect residents current care level. Resident #8's CPAP Care Plan and treatment sheet were updated on 10/23/14 to reflect the appropriate setting.<br>2. All residents have the potential to be affected. Through admit assessment, quarterly MDS review and prn change of status review, monthly care plan audits residents will be identified for care plan updates. | 11/17/14 |

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| VALLEY VISTA CARE CENTER OF ST MARIES | 820 ELM STREET<br>ST MARIES, ID 83861 |

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but no longer resided there;
*did not document a change of condition for ADLs and urinary incontinence; and
*did not document a setting for a CPAP machine.
This had the potential to result in harm if residents did not receive appropriate care due to lack of direction in care plans. Findings included:

1. Resident #1 was readmitted to the facility on 5/30/14 with multiple diagnoses including chronic obstructive pulmonary disease.

The resident's Potential for Impaired Gas Exchange care plan dated 5/30/14, documented an intervention of, "Oxygen (Mask, Cannula) per order."

The resident's October 2014 Physician Order Report and TAR did not document the resident received oxygen therapy.

The resident's room was observed on 10/20/14 at 1:33 PM and throughout the survey and did not contain an oxygen apparatus.

On 10/22/14 at 3:10 PM, the Behavior Care Program Coordinator was interviewed regarding the care plan. She said the resident was no longer receiving oxygen and the care plan had not been updated to reflect the change.

2. Resident #4 was admitted to the facility on 3/14/11 with multiple diagnoses which included Alzheimer's Disease and psychosis.

Resident #4's Mood/Behavioral Alteration Care Plan, with an origin date of 5/18/11, documented interventions which included, "CONTINUE SECURED UNIT PER ASSESSMENT."

F 280 3. In servicing was done on 11/4/14 for nursing staff on care plan and treatment plan accuracy. Monthly care plan audits and prn change of status reviews were initiated 11/14/14.
4. The DNS or designee will follow this issue in QA review by a monthly care plan audit and prn change of status reviews and report to the QA committee beginning 11/17/14. We will continue in-servicing staff for care planning accuracy and have increased our external audits.

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The October 2014 recapitulated Physician's Orders for Resident #4 documented, "BCP NON-SECURE UNIT PER ASSESSMENT," with an origin date of 5/18/11.

A Non-Secured Behavior Unit Assessment, dated 4/24/14, documented Resident #4, "...moved to our Non-Secure Behavior Care Unit..."

Resident #4 was observed to reside on the non-secure behavior care unit from 10/20/14 to 10/22/14 and throughout the survey process.

On 10/22/14 at 10:45 a.m., the Behavior Unit Program Manager (BUPM) was asked which unit Resident #4 resided and she stated, "She's on the non-secured [unit]. She was on the secured [unit]." After the BUPM reviewed Resident #4's Care Plan, she stated, "Yep, this one says secured. I'll change it."

On 10/22/14 at 5:50 p.m., the Administrator and DON were informed of the care plan issues. No further information or documentation was provided.

3. Resident #6 was admitted to the facility on 2/15/12 with multiple diagnoses including Alzheimer's disease.

The resident's most recent quarterly MDS assessment, dated 7/11/14, documented:
*The resident was unable to be interviewed for the cognition BIMS Score;
*Exhibited rejection of care 4-6 days per week but less than daily;
*Was independent to eat and needed setup help only;

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*Needed extensive assistance of 2 + persons for bed mobility, transfers, walk in room and corridor, locomotion on unit and toilet use;
*Needed extensive assistance of 1 person for locomotion off unit;
*Wandered on a daily basis; and,
*Frequently incontinent for bladder and bowel.

The resident's most recent significant change MDS assessment, dated 9/17/14, documented:
*The resident's cognition was not assessed;
*Exhibited rejection of care occurred 1-3 days per week;
*Needed total assistance of 2 + persons for transfers and toilet use;
*Needed total assistance of 1 person for locomotion on and off the unit
*Walk in room and corridor did not occur;
*Needed extensive assistance of 1 person with eating; and,
*Always incontinent of bladder and bowel.

The Care Area Assessment (CAA) portion of the significant change MDS assessment documented, "A significant change is being done due to increased need of assist, decreased communication, not understanding tasks, etc,...ability to participate in conversation or verbalize in a coherent manner is non-existent...this is likely related to the advancement of Alzheimer's...now requires a Hoyer for all of her transfers and uses a Broda chair d/t [due/to] safety issues...she requires extensive to total care for all of her ADL's...now totally incontinent of B&B [bladder and bowel] and requires total care for all of her toileting needs...totally dependent on staff to meet all of her needs."

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| F 280 | Continued From page 11<br>Resident 6's Care Plan documented the following:<br>*"Self Care Deficit - Resident tends to get in others space, and is intrusive, can get angry and aggressive with redirection. She is impulsive and can get up and move, but is now using W/C [wheelchair] and sometimes resistive to walking with staff (11/22/13)..."<br>*Incontinence - Wearing pull-ups (full liners at this time 2/17/14) with a goal of the number of incontinent episodes will be minimized...requires extensive assistance of 1-2 for all ADL care." An intervention documented, "Check liner Q [every] 2 hours for incontinence while awake..."<br>The ADL Care Plan, used by CNA's, documented in the Transfer section, "Extensive 1-2 assist w/gait belt, Hoyer lift prn." The Toilet Use section, documented the resident used "Liners."<br><br>On 10/22/14 at 9:50 AM, CNA #6 was observed to change the resident's Attends (adult brief). The surveyor inquired if the resident wore pull-ups and CNA #6 stated, "The resident wears a full Attends now."<br><br>On 10/22/14 at 5:15 PM, the DON was asked about the resident's current status and shown the Self Care Deficit Care Plan. The DON stated, "Yes, it doesn't look like it's been updated. The ADL Care Plan should be updated according to the MDS assessment. The 1-2 assist with gait belt shouldn't be on here, it should have been DC'd (discontinued) and should say Hoyer only."<br><br>On 10/23/14 at 9:10 AM, the DON was shown the Incontinence Care Plan and asked if it had been updated to reflect the resident's current status. The DON stated, "No, I have to agree, it needs to be updated." | F 280 | | |

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4. Resident #8 was admitted to the facility on 5/19/10 with multiple diagnoses which included chronic obstructive pulmonary disease (COPD), chronic respiratory failure and obstructive sleep apnea.

A care plan for the problem of Impaired Gas Exchange had been developed with an origin date of 11/15/06 related to COPD/Chronic Respiratory Failure/Morbid Obesity. An intervention documented, "C-PAP per MD orders for settings. To wear at night."

Physician Order Report (recapitulation) effective 10/1/14, documented the following order: *"CPAP on at 2100 (9:00 PM) with a start date of 6/4/10."

NOTE: The order did not document a CPAP Setting.

Record review of the resident's TAR for October 2014, documented, "CPAP on at 2100 - sleep apnea," and did not document a setting for the CPAP machine.

On 10/23/14 at 10:15 AM, the DON stated, "There was an original order for the CPAP settings when the resident was first admitted."

On 10/23/14 at 1:35 PM, the DON provided a copy of the original CPAP order, dated 5/19/10, which documented, "CPAP @ 12 at night and PRN - COPD/Sleep apnea." The DON stated, "The settings should be on the recapitulation orders and in the care plan, the settings must have dropped off when the order was carried over."

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| F 280 | Continued From page 13<br>On 10/23/14 at 3:50 PM, the Administrator and the DON were made aware of the issues regarding care plans. The facility did not provide any further information which resolved the concern. | F 280 | | |
| F 315<br>SS=G | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and record review, it was determined the facility failed to ensure residents with urinary catheters received necessary care and services to prevent urinary tract infections. This was true for 2 of 2 (#s 1 & 2) sampled residents reviewed for urinary catheters. Resident #2 was harmed when she acquired 3 urinary tract infections and required hospitalization for urosepsis. Resident #1 had a urinary catheter in place with no correlating care plan or documentation of catheter care, which created the potential for urinary tract infections or other complications associated with indwelling catheter use. Findings included:<br><br>The Suprapubic Catheter Care Policy and | F 315 | 1. Resident #1's TAR and CNA flow sheet was updated immediately on 10/23/14. Resident #2's TAR, CNA flow sheet and ADL Care Plan was updated immediately on 10/23/14.<br>2. All residents with catheters have the potential to be affected. Through admit assessment, quarterly Restorative Nursing review, prn change of status review and through daily rounds residents with symptoms of UTI's will be identified for proper treatment and care planning.<br>3. Beginning 10/24/14 on the spot review of catheter care was done with infection control nurse and CNA staff. In-serving was done on 10/28/14 and 10/30/14 regarding catheter care documentation. A follow | 11/17/14 |

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| F 315 | Continued From page 14<br>Procedure, revised on 10/10, documented, "...Documentation. The following information should be recorded in the resident's medical record: 1. The date and time the procedure was performed. 2. The name and title of the individual(s) who performed the procedure. 3. All assessment data obtained during the procedure. 4. How the resident tolerated the procedure. 5. If the resident refused the procedure, the reason(s) why and the intervention taken. 6. Results of skin assessment around the stoma site. 7. Character of urine such as color...and odor. 8. Any problems or complaints made by the resident during the procedure. 9. The signature and title of the person recording the data..."<br><br>1. Resident #2 was readmitted to the facility on 9/20/14 with multiple diagnoses which included multiple sclerosis (MS) and paraplegia.<br><br>The most recent significant change MDS assessment, dated 9/23/14, documented Resident #2 had moderate cognitive impairment with a BIMS of 12, had an indwelling catheter and required total assistance of 2 people for toilet use.<br><br>Resident #2's ADL Care Plan documented the Toileting Plan was discontinued on 5/12/14 and a handwritten revision documented, "Suprapubic cath[eter] placed - empty [and] record cc's [cubic centimeters]. Cath care per protocol."<br><br>Resident #2's Care Plan, dated 9/20/14, documented the problem of suprapubic catheter with potential for UTI's [Urinary Tract Infections] related to MS, history of urosepsis and neurogenic bladder. Interventions included monitoring for signs and symptoms of UTI and urosepsis, and suprapubic catheter care every | F 315 | up mini in-service was done on 11/14/14 to summarize changes in catheter care documentation. Ongoing monthly staff education will be performed on care documentation beginning 10/28/14. Catheter care documentation will be required on CNA flow sheets with signature and nursing supervision will be documented on the TAR Q shift with nurse's signature as of 11/01/14. All new orders will be reviewed in daily IDT meetings and MARS and TARS will be reviewed by DNS or designee for accuracy as of 11/13/14.<br>4. The DNS or designee will follow this issue in QA review and report to the QA committee for three months beginning with our next scheduled QA meeting on 11/17/14. After three months the QA committee will determine the ongoing auditing frequency. | |

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| F 315 | Continued From page 15<br>shift.<br><br>The July through October 2014 Care Plan Flow Sheets for Resident #2 documented suprapubic catheter care was to occur every shift. This was on the flow sheet as, "Info Only," and did not require documentation. The Flow Sheets included the statement, "I HAVE GIVEN CARE ACCORDING TO ADL CARE PLAN...," which was documented with initials every shift.<br><br>The following documentation was gathered from Resident #2's Physician's Telephone Orders (PO), Care Plan (CP), Treatment Administration Record (TAR), Urology Reports (UR), History and Physical (H&P) and Interdisciplinary Progress Notes (PN):<br>* 3/25/14 (UR) - "Genitourinary: Patient complains of dysuria...Plan: Patient with advanced multiple sclerosis causing neurogenic bladder and probable urinary retention. This could very well be leading to her recurrent urinary tract infections. I explained to the patient that the only effective treatment for such problem would be either intermittent catheterization or permanent catheterization with suprapubic catheter or a Foley catheter to down drain...;"<br>* 5/12/14 (CP) - Handwritten revision, "Suprapubic cath[eter] placed - empty [and] record cc's [cubic centimeters]. Cath care per protocol;"<br>* 5/12/14 (TAR) - "Follow Foley Cath Care sheet provided;"<br>(Note: Documentation with initials was not required on the TAR)<br>* 5/28/14 (PN) - "...Catheter patent draining dark urine...;"<br>(Note: TAR for June 2014 did not contain documentation of catheter care.) | F 315 | | |

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| F 315 | Continued From page 16<br>* 6/6/14 (PO) - "Ampicillin 500 mg PO TID x 7 days;"<br>* 6/13/14 (PN) - "...dark amber blood tinged urine in cath bag...;"<br>* 6/13/14 (PO) - "Reculture urine. Continue Ampicillin for 5 more days;"<br>* 6/15/14 (PO) - "Amox[icillin] 250 mg po q [every] 8 [hours] until Ampicillin available;"<br>* 6/24/14 (PN) - "...clarification of abx [antibiotics] orders. Explained resident is asymptomatic...dark amber/red urine [with] visible sediment...;"<br>* 6/24/14 (PO) - "Augmentin 875 mg PO BID x 7 days;"<br>(Note: TAR for July and August 2014 did not contain documentation of catheter care.)<br>* 8/24/14 (PN) - "...Resident was [with] s/sx of UTI i.e. [change] in character of urine, worsening of mental/functional status. Dip performed [with] results of Nitrates [and] blood off the chart...PCP notified. NO [New orders] received...;"<br>* 8/24/14 (PO) - "Rocephin 1 gm IM Daily x 5 days. Urine C&S [Culture & Sensitivity];"<br>* 9/11/14 (TAR) - "Assess SP insertion site Q [Every] PM - Cleanse;"<br>(Note: On 9/16/14 the TAR had no initials documenting the catheter care had been performed.)<br>* 9/16/14 (PN) - "Resident unable to respond to questions at this time, very little P.O intake noted. [No] calling out from room, [no] movement noted...family called...;"<br>* 9/16/14 (PN) - "...agreed to notify MD of condition change...;"<br>* 9/17/14 (PN) - "[Resident's name] is nonverbal, [increased] lethargy...urine = hematuria [at] this time;"<br>* 9/17/14 (PN) - "...in bed eyes half closed, unable to swallow am meds, not able to make needs known verbally or [with] cue cards...cath | F 315 | | |

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[with] dark orange urine in bag [and] tubing, PCP called left message [with] update, return call [with] order to send to ER...;"
* 9/17/14 (PO) - "Admit to [local hospital] for tx [treatment] of Urosepsis;"
* 9/17/14 (PN) - "[Local hospital] reports Resident admitted for eval and treat of suspected urosepsis;" and,
9/17/14 (H&P) - "History of Present Illness:...The patient transferred to the emergency room for evaluation due to decreased mental status...Assessment and Plan:...3. Suspect acute exacerbation of bladder infection, given catheter source..."
(Note: On 9/27 through 9/29/14 the TAR had no initials documenting the catheter care had been performed. In addition, the October 2014 TAR did not contain documentation of catheter care.)

Resident #2 was observed to have a urinary catheter in place on 10/21/14, 10/22/14 and throughout the survey process.

On 10/23/14 at 9:20 a.m., LN #5 was interviewed about Resident #2's multiple urinary tract infections and catheter management. The LN said the resident showed symptoms of UTI's with, "Slurred speech, a lot more confused," and the temperature would spike. "The Aides" were responsible for catheter care every shift and the nurses would oversee the care that was performed. When asked where catheter care was documented, the LN stated, "I'm sure it's on their ADL flow sheets. I know it's on the TAR." After reviewing the ADL flow sheets and TAR, the LN stated, "That needs to be changed, can't believe it isn't on the TAR. You would think medical records put it on there. That will definitely be changed." LN #5 added when the CNA's initial the

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statement of giving care according to the ADL Care Plan, catheter care was part of ADL care. The LN stated, "I can tell you it's being done," and Resident #2 got the suprapubic catheter for the recurrent UTI's because the bladder was not emptying.

On 10/23/14 at 10:55 a.m., with the Administrator and Corporate Compliance Nurse (CCN) present, LN #5 told the surveyor she had "already fixed the TAR and CNA Flow sheets." When asked why catheter care was added to the TAR in September but not the previous months, the LN stated, "I wouldn't have written that on there if it was already on the TAR." The RNC looked through the TARs from June through September 11 2014 and October 2014 and did not find catheter care documentation for Resident #2.

On 10/23/14 at 2:25 p.m., the Administrator, with LN #5 and CCN present, said if catheter care was on the ADL Care Plan that the blanket statement meant it was performed, and it was not productive for the CNA's to chart on each and every item on the Care Plan. LN #5 stated the nurse who wrote the catheter care on the TAR in May 2014 did not make it for people to document or sign it had been performed. The Administrator stated, "Per our policy, the charting is not adequate."

On 10/23/14 at 4:10 p.m., the Administrator, DON and CCN were informed of the concerns with infections and suprapubic catheter care. The DON acknowledged the concern and stated, "It should have been on there [TAR]."

On 10/27/14, further documentation was provided by the facility for Resident #2, however, it did not resolve the issue.

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| VALLEY VISTA CARE CENTER OF ST MARIES | 820 ELM STREET<br>ST MARIES, ID 83861 |

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2. Resident #1 was readmitted to the facility on 5/30/14 with multiple diagnoses including dementia with behavioral disturbances and urinary incontinence.

The facility's Catheter Care policy, revised on October 2010, documented:
"The following information should be recorded in the resident's medical record:
1. The date and time that catheter care was given.
2. The name and title of the individual(s) giving the catheter care.
3. All assessment data obtained when giving catheter care..."

The resident's Physician's Telephone Orders, dated 10/3/14, documented staff was to place a foley catheter for urinary retention until a surgical consult appointment was completed.

The resident's Interdisciplinary Progress Notes (IPN) documented a foley catheter was placed on 10/3/14. The resident's IPN documented from 10/3 to 10/20/14, the catheter was intact with a description of the urine color, however the notes did not document catheter care was performed.

The resident's ADL or Urinary care plans did not document the resident had a foley catheter in place and did not document who would complete catheter care.

The resident's October 2014 TAR did not document the resident had a foley catheter, did not include when to change the catheter bag and did not include an area to document catheter care.

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| F 315 | Continued From page 20<br><br>On 10/20/14 at 1:33 PM and throughout the survey, the resident was observed to have a catheter.<br><br>On 10/22/14 at 3:10 PM, the Behavioral Care Program Coordinator was interviewed regarding the catheter issues. When asked to review the care plan to see where the catheter was addressed, she stated, "There's nothing in here I can see." When asked if information was on the TAR or MAR about the catheter, she stated, "I don't see anything on the MAR."<br><br>On 10/23/14 at 3:50 PM, the Administrator and DON were informed of the catheter issues.<br><br>On 10/27/14 at 4:35 PM, the facility faxed additional information regarding the catheter issues, however the information did not resolve the concerns. | F 315 | | |
| F 323<br>SS=G | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, it was determined the facility did not ensure 2 of 6 (#'s 1 & 6) sampled residents for falls was | F 323 | 1. Resident #1 was immediately sent to ER for evaluation by a physician. New interventions were added to resident #6's care plan after each fall. After fall from bed on 8/15/14, resident was care planned to be angled towards wall when positioned up in bed. After fall from bed on 8/24/14, resident had been assessed for a concave mattress and concave | 11/17/14 |

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| F 323 | Continued From page 21<br>provided adequate supervision. Resident #1 was harmed when staff failed to provide one on one supervision as directed by the care plan and the resident stood unattended and fell, which caused a left hip fracture and required surgical intervention. Additionally, the facility failed to provide adequate supervision when Resident #6 experienced four falls. Finding included:<br><br>1. Resident #1 was admitted to the facility on 6/3/11 and readmitted to the facility on 5/30/14 with multiple diagnoses including dementia with behavioral disturbances, osteoporosis, curvature of spine, anxiety, paranoia, and psychosis.<br><br>The resident's 5/9/14 quarterly MDS assessment, documented the resident:<br>*Was severely cognitively impaired, BIMs = 1;<br>*Had signs of inattention and disorganized thinking;<br>*Required extensive assistance with two staff to transfer; and,<br>*Not steady, when moving from seated to standing position.<br><br>The resident's Fall Risk Evaluation, dated 5/9/14, documented the resident was a high risk for falls.<br><br>The resident's Fall care plan, dated 2/18/14, documented the resident was at a high risk for falls related to a right hip fracture, dementia, osteoporosis and paranoia.<br>Interventions included, "If awake and restless at night when roommate is sleeping, bring to common area and provide an activity or 1:1 [one on one] time."<br><br>The resident's ADL care plan, dated 2/18/14, documented an intervention of, "Do not leave | F 323 | mattress was placed on 8/26/14. On 8/28/14 resident lunged forward out of her w/c when being transported by staff. Resident was screened for appropriateness in w/c by PT on 9/10/14 and was placed in new w/c. On 9/12/14 resident rolled out of bed. Pillows were used as bolsters to for safety and the air mattress was changed to an air mattress with foam bolster surrounding the mattress on 9/25/14.<br>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.<br>3. Staff in-services on meeting the needs of the cognitively impaired and fall prevention beginning on 10/28/14 and ongoing. | |

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| F 323 | Continued From page 22<br>unattended in common area. Provide 1:1 time as needed for safety and behaviors."<br><br>A facility "Fall Scene Investigation", dated 5/26/14, indicated the resident fell on 5/26/14 at 10:25 PM in front of the nurses station. The investigation documented the resident was confused and wanted to walk prior to the fall. The facility identified the root cause as, "Possibly hip fx [fracture] then she fell."<br><br>A staff statement attached to the investigation, dated 5/26/14 regarding the fall, documented by CNA #3:<br>"I was sitting at the nurses station and I was getting ready to sign the wheelchair paper when I heard [Resident #1's] alarm, her pull-tab alarm go off. I looked up and I seen [sic] her standing up in front of her wheelchair. [CNA #4] told me to go and have her sit down, so I got up and was going to [Resident #1] to have her sit back down, however by the time or before I even got to her, she had fallen. I was right at the edge of the nurses station when she went down...She had already stood up once, because she wanted to walk around. We got her to sit back down, and told her that as soon as we were done, that [CNA #4] was or would take her on a walk. She was happy with that and she sat right back down. And after I signed the wheelchair paper, I was going to get the alarm checklist and take care of that."<br><br>A staff statement attached to the investigation, dated 5/26/14 regarding the fall, documented by CNA #4:<br>"[Resident #1] was in her wheel chair with alarm pull tab on. She had stood up once I [CNA #4] had sat her back down, told her we would walk her when I got my paperwork done. [CNA #3] had | F 323 | 4. The DNS or designee will follow this issue in QA review and report to the QA committee starting 11/17/14. This will be ongoing in our weekly IDT meetings where we monitor residents at risk for falls, residents with significant change and newly admitted residents to the facility. | |

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| F 323 | Continued From page 23<br>just came to get alarm check list and [Resident #1] had stood up again and before [CNA #3] or myself could get around the station she had stood and fell it was 10:25 PM [sic]."<br><br>A "Memorandum For Record" attached to investigation, dated 6/4/14, documented: "CIRCUMSTANCES SURROUNDING ACCIDENT: resident was sitting in her w/c [wheelchair] at the nurse's station and had been attempting to stand AEB [as evidenced by] alarm sounding when she tried. She was told at least once to remain sitting and they would take her for a walk when they finished up some paperwork on the other side of the nurse's station. She stood from her w/c and before staff could get around the nurse's station to reach her, she fell to the floor."<br>The Conclusion documented, "given resident's prominent degenerative changes in her spine and hips, this fall could have happened because of osteoporosis. Never the less, she broke her hip because she stood and before staff could reach her she fell."<br>The "Plan" documented:<br>"1. Staff education regarding residents needs being met before paperwork.<br>2. Continue in the behavior program with increased staffing.<br>3. Continuing staff in-service's [sic] on meeting the needs of the cognitively impaired..."<br><br>The resident's Interdisciplinary Progress Notes documented the resident was transferred to a local hospital on 5/26/14 at 10:53 PM via ambulance.<br><br>A local hospital record, dated 5/27/14, documented the resident was admitted to the | F 323 | | |

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| F 323 | Continued From page 24<br>emergency room, "...with left hip fracture after a ground-level fall." The hip fracture required surgical repair.<br><br>On 10/22/14 at 3:10 PM, the Behavior Care Program Coordinator was interviewed regarding the incident. She reviewed the investigation and staff statements. When asked if staff chose to complete paperwork over resident care she stated, "I don't discount that." She also said because of the incident, staff was re-educated to put resident care before paperwork. When asked about the Memorandum conclusion, she stated, "I still think it could have been osteoporosis." When asked if the resident's physician supported this theory, she stated, "No he didn't." Note: The resident's Physician progress notes did not document the resident suffered from spontaneous fractures due to osteoporosis.<br><br>On 10/23/14 at 10:30 AM, the Administrator and Corporate Compliance Nurse asked the surveyor to review the fall incident with them. During the discussion, the Administrator stated regarding the incident, "Staff made an error and could have done something different."<br><br>The facility did not ensure they kept the resident safe when she stood twice without assistance and fell on the second attempt, even though she was a high fall risk, was unable to maintain balance, was severely cognitively impaired with inattention, and staff chose to complete paperwork over caring for the resident's one on one needs as directed by the care plan.<br><br>On 10/23/14 at 3:50 PM, the Administrator and DON were informed of the issues. | F 323 | | |

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On 10/27/14 at 4:35 PM, the facility faxed additional information regarding the incident, however the information did not resolve the concerns.

2. Resident #6 was admitted to the facility on 2/15/12 with multiple diagnoses including Alzheimer's disease.

The resident's most recent quarterly MDS assessment, dated 7/11/14, documented:
*The resident was assessed by the facility to have severely impaired decision making abilities, and
*Needed extensive assistance of 2 + persons for bed mobility, transfers, walk in room and corridor, locomotion on unit and toilet use.

On 8/6/14 a Physician Progress note documented the resident was, "becoming more withdrawn and nonverbal over time. I have seen a change markedly in the last 6 months. She is not getting up and walking around as she used to...she does smile occasionally but is not attempting to communicate with me, as in the past."

Record review documented Resident #6 had four falls between 8/15/14 and 9/12/14:

a. The resident's first fall occurred, on 8/15/14 at 9:00 PM. She was propped up in bed after coffee ground emesis were discovered at 5:10 PM. The nursing progress notes for 8/15/14 Days documented, "Resident alert, active moving self about in W/C to D/R [dining room]." The Incident Report, dated 8/15/14, documented, "Res[ident] has continual movements and will now be propped towards wall." The new intervention to prevent falls documented, "Angle towards wall, already on Falling Star Program."

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| F 323 | Continued From page 26<br><br>NOTE: The resident was found on the floor 4 hours after being propped up in bed.<br><br>b. The resident's second fall occurred, on 8/24/14 at 10:15 PM, when the resident was found on the floor beside her bed. The Fall Scene Investigation Report, dated 8/24/14, documented the fall was unwitnessed and the resident was found when staff looked in the resident's room and saw her "in a fetal position laying on her left arm, not moving, just laying there." The Accident Report CNA/NA, which was not signed or dated, for the 8/24/14 fall documented, "[Resident #6's] alarm went off and we went running, saw [Resident #6] on the floor, looked like she rolled off bed." The new intervention to prevent falls documented, "Continue pull tab and motion alarms, continue 15 minute visual checks, and consider appropriateness of concave mattress." The medical record did not contain evidence of increased supervision. No documentation of 15 minute checks was found.<br><br>c. The resident's third fall occurred, on 8/28/14 at 5:12 PM, as a result of being pushed in her wheelchair down the hallway. The nursing progress notes, before the fall, documented:<br>*No time given, "[Resident #6] is very anxious, awake, grabbing at things, her left side of face appears to be swollen..."<br>*2:30 PM, "Res[ident] with watery diarrhea, put on contact precautions to no [sic] intestinal virus."<br>After the fall, the nursing progress notes documented:<br>*9:30 PM, "At 5:12 PM resident was being transferred or pushed by W/C out of room and suddenly planted feet and lunged forward. Staff pushing resident was able to slow impact by | F 323 | | |

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grabbing resident's shirt but resident fell forward on to face, resulting in 3 cm abrasion with contusion to forehead...Resident maintains a forward leaning posture whenever up in W/C."

The Fall Scene Investigation Report, dated 8/28/14, documented the resident was, "Reaching forward and lost balance...agitated r/t [related to] pending room change and activity redirection and lunged from chair..." A Staff Statement, dated 8/28/14 at 5:15 PM, documented, "I was coming down the hall just after a med[ication] pass when I saw [Resident #6] being wheeled out of her room to be moved for isolation precautions, just after she passed the door threshold she bent forward very quickly reaching towards the ground as she is prone to do. She overreached after propelling herself completely out of the W/C landing on her forehead and knees." The new intervention to prevent falls documented, "Increased staff supervision, treat for anxiety, request therapy consult for possible geri-chair related to forward bearing posture. Therapy screened and cushion - chair appropriate." Additionally, the root cause section of the Fall Scene Investigation Report documented a contributing factor of the fall was agitation. However, the resident's fall care plan had not been updated to address how staff would respond if the resident was agitated while in the W/C.

d. The resident's fourth fall occurred, on 9/12/14 at 8:28 PM, when the resident rolled out of bed and was found on the floor. A nursing progress note, dated 9/12/14 at 9:30 PM, documented, "Res[ident] found at 8:28 PM on floor by bed." An Accident Report, dated 9/12/14, documented, "I heard a thump, then alarms and found the

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| F 323 | Continued From page 28<br>resident laying on the floor on her right side. She rolled out of bed." A Fall Scene Investigation Report, dated 9/12/14, documented, "Res[ident] rolled OOB [out of bed] and hit occiput [back part of the head] and possibly right elbow on side table." A Resident Incident Report, dated 9/12/14, documented, "...Res[ident] was on floor next to bed, supine, skin tear to right lateral elbow and small laceration to right occiput most likely from side table." The new intervention to prevent falls documented, "Side table moved to end of bed, pillows to bolster resident in place, and foam surround air mattress with bolster."<br><br>On 10/22/14 at 5:15 PM, the DON was interviewed regarding the four falls the resident experienced from 8/15/14 to 9/12/14. When asked for documentation of increased supervision, the DON stated, "We don't have documentation for 15 minute checks because everyone is checked 15-30 minutes. If they are on the Falling Star Program, the resident is checked every 15 minutes and this resident is on the Falling Star Program." The DON pointed to The Fall Scene Investigation Reports for each fall and the interventions placed to prevent future falls.<br><br>The facility failed to ensure Resident #6 was free from falls and could not provide documentation of increased supervision to keep the resident from falling even though they knew she was a high fall risk and was severely cognitively impaired. | 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 | F 329 | 1. An order was received for resident #6 to D/C scheduled Klonopin on 10/23/14. | 11/17/14 |

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| F 329 | Continued From page 29<br>drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not 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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, it was determined the facility failed to ensure residents were free from duplicate therapy. This was true for 1 of 9 (#6) sampled residents. This failure placed the resident at risk for harm as duplicate therapy can lead to overmedication, adverse reactions and health decline. Findings included:<br><br>Resident #6 was admitted to the facility on 2/15/12 with multiple diagnoses including Alzheimer's disease. | F 329 | 2. All residents that use antipsychotic medications have the potential to be affected. Through admit assessment, quarterly MDS review and prn change of status review residents with the potential for dual therapies will be identified.<br>3. Resident status changes will be communicated via IDT meetings held daily and in IDT weekly review meeting starting 11/11/14. Physician orders with information regarding resident status will be given to DNS or behavior nurse coordinator for possible medication needs starting 11/11/14 in daily IDT meeting. Request for psychotropic medication needs/changes will be reviewed DNS or designee who will then follow up with primary care physician and/or psychiatrist starting 11/11/14. Behavior nurse coordinator will ensure proper documentation is obtained by prescribing | |

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| VALLEY VISTA CARE CENTER OF ST MARIES | 820 ELM STREET<br>ST MARIES, ID 83861 |

| (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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The resident's quarterly MDS assessment, dated 7/11/14, and significant change MDS assessment, dated 9/17/14, documented the resident was, "unable to be interviewed for the cognition BIMS Score."

The Physician Order Report (recapitulation) for October 2014 documented the following orders for the diagnosis of anxiety:
*"Klonopin 0.5 mg 1 tab PO Q [every] HS, and
*Alprazolam 0.25 mg PO TID PRN.

NOTE: Klonopin is a long acting benzodiazepine used for the diagnosis of anxiety and Alprazolam is a short acting benzodiazepine used for anxiety. Benzodiazepine use can contribute to somnolence (state of sleepiness), low blood pressure, impaired motor function, such as dizziness, impaired balance, muscle weakness, impaired reflexes and can lead to falls in the elderly.

Resident #6's medical record contained documentation the resident had an increase of anxiety from 15% to 61% as contained in the 6/2/14 IDT (Interdisciplinary Team) review. The review documented the resident needed, "something different for anxiety; maybe Klonopin?"

On 6/12/14 a Physician's Telephone Order documented, "Klonopin 0.25 mg po BID with an increase to Klonopin to 0.5 mg po BID in 2 weeks if tolerated for anxiety."

A 9/9/14 IDT review documented, "There were 10 uses of prn Xanax in Aug[ust], 13 in July and 22 in June prior to the scheduled Klonopin...the scheduled Klonopin has proven effective in

F 329 physician with any medications that may be considered dual therapies. Quarterly reviews with consulting psychiatrist will include requests for documentation for justification of dual therapies if physician finds them appropriate. Behavior nurse coordinator will continue practice of Q administration time ASE summary with regular psych tab note by same. This will include the use of PRN's and whether or not the regime is effective for meeting target symptoms.
4. The DNS or designee will follow this issue in QA review through weekly IDT meetings and report to the QA committee. This will be ongoing.

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lowering her anxiety levels."

Record review of the resident's Incident and Accident Reports documented the resident fell out of bed on 8/15/14, 8/24/15 and 9/12/14.

On 9/25/14 a Physician's Telephone Order documented, "Comfort measures only r/t [related to] advanced dementia, failure to thrive. Decline anticipated."

On 9/30/14 a Physician's Telephone Order documented, "Change Klonopin to: 0.5 mg one tab po Q HS/anxiety. DC [discontinue] prior scheduled dosages."

On 10/23/14 at 12:00 PM, the DON was asked if the facility had justification for the use of two benzodiazepines for the diagnosis of anxiety. The DON stated, "We do not have justification for duplicate therapy."

On 10/23/14 at 1:35 PM, the DON provided information regarding why the Klonopin was added to the resident's drug regimen. When asked if the facility had documentation for using multiple medications from the same pharmacological class, the DON stated, "We don't have physician justification for the use of both Klonopin and Xanax (Alprazolam). I did talk with LN #8 who got an order to discontinue the scheduled Klonopin."

On 10/23/14 at 3:45 PM, the Administrator and DON were made aware of the duplicate therapy concern.

On 10/27/14 at 4:35 PM, the facility faxed additional information to the Bureau of Facility

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| F 329 | Continued From page 32<br>Standards which did not resolve the issue. | F 329 | | |
| F 431<br>SS=E | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>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. | F 431 | 1. The medication card was removed from the cart immediately on 10/22/14 and replaced with new card with current order. 2. The expired medications found in the East Medication Cart were immediately removed and destroyed by the licensed nurse. 3. Expired medication found in the medication room was immediately disposed of.<br>2. All residents have the potential to be affected. As all residents receiving medication have the potential to be affected, a 100% medication audit was conducted on 11/14/14, no other inaccuracies were found.<br>3. Direction change labels were obtained from pharmacy to indicate change in frequency of medication dosage. Staff in-services on expired medications and labeling of medication | 11/17/14 |

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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 were accurately labeled;
*Expired medications were not available; and,
*An expired glucose control bottle was not available for use.
This was true for 1 of 10 residents (#17) sampled for accuracy of medication labels, 1 of 1 medications rooms and 1 of 3 medication carts sampled for expired medications. This failed practice created the potential for harm if residents received sub-optimal efficacy from expired medications, inaccurately labeled anticoagulant medications, and, inaccurate readings from blood glucose machines. Findings included:

1. On 10/22/14 at 2:50 PM, during the medication pass observation for Random Resident #17, a label for Coumadin 2 mg documented to "take one tablet by mouth once daily." LN #9 stated, "This order has changed and the resident now receives Coumadin 2 mg everyday except on Tuesdays and Thursdays when he receives 4 mg."

On 10/13/14 a Physician's Telephone Order in the resident's medical record documented, "Increase Coumadin 2 mg q [every] day; 4 mg Tuesday and Thursday. Recheck PT/INR [prothrombin time/international normalized ratio] (a lab test used to monitor the effectiveness of the anticoagulant Coumadin) 2 wks [weeks] d/t [due/to] INR 1.39."

The October 2014 MAR documented the 10/13/14 order for increasing the Coumadin;

F 431 changes were performed on 10/28/14 and 10/30/14. Ongoing weekly medication cart and medication room audits began 11/14/14.
4. How will you monitor this issue so that it will not happen again? The DNS or designee will follow this issue in QA review and report to the QA committee beginning 11/17/14. This will be ongoing.

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| F 431 | Continued From page 34<br>however, the label documented the 9/23/14 order.<br><br>2. On 10/23/14 at 8:30 AM, during an inspection of the East Medication Cart with LN #2, the following expired medication bottles were found:<br>*Loperamide HCl 2 mg tabs, with 5-6 tabs remaining, expired 2/2014.<br>*Liquid Pain Relief, Acetaminophen 160 mg/ 5 ml, 16 fluid ounce bottle (473 ml), Cherry Flavor, 3/4 full, expired 9/2014.<br><br>LN #2 immediately took the aforementioned expired medication bottles to the East Nurse'ss Station Medication Room and destroyed them according to the facility's policy and procedure.<br><br>3. On 10/23/14 at 10:55 AM, during an inspection of the East Nurse's Station Medication Room with LN #10, the following expired glucose control bottle was found:<br>*True Control, Level 2, 3 ml bottle with an expiration date of 9/30/14.<br><br>LN #10 immediately emptied the remaining blood glucose control fluid down the sink. LN #10 was informed of the expired medications found on the East Medication Cart.<br><br>On 10/23/14 at 3:45 PM, the Administrator and DON were informed of the inaccurate label for Coumadin, expired medications and glucose control found during the medication observation task. No further information was provided by the facility. | F 431 | | |
| F 441<br>SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an | F 441 | 1. CNA #7 was educated on 10/23/14 by the DNS for proper hand washing. | 11/17/14 |

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| F 441 | Continued From page 35<br>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of | F 441 | 2. All residents have the potential to be affected.<br>3. Staff in-services on infection control and hand washing were done on 10/28/14 and 10/30/14 by the DNS and will be ongoing. Weekly QA rounds for 4 weeks and then three months beginning 11/17/14.<br>4. The DNS or designee will follow this issue in QA review and report to the QA committee beginning with December QA meeting. | |

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| F 441 | Continued From page 36<br>facility policy and staff interview, it was determined the facility failed to ensure standard precautions for hand washing were used by staff in preventing infections. This was true for 1 of 9 sampled residents (#6) for review for infection control concerns and placed residents at risk for infections due to transmission of microorganisms. Findings included:<br><br>Resident #6 was admitted to the facility on 2/15/12 with multiple diagnoses including Alzheimer's Disease.<br><br>The resident's most recent significant change MDS assessment, dated 9/17/14, documented:<br>*Total assistance of 2 + persons for transfers and toilet use.<br>*Always incontinent of bladder and bowel.<br><br>On 10/21/14 at 11:20 AM, two CNA's were observed to assist with changing the resident's adult brief. CNA #7 removed her gloves, placed them in the trash bag containing the contaminated brief and tied a knot in the trash bag. CNA #7 then pushed the EZ Lift Equipment with one hand, picked up the trash bag with the other hand and pushed the lift out of the resident's room. CNA #7 returned the lift to a hall storage area and then opened the door to the Soiled Utility Room to deposit the trash bag. Once the trash bag had been deposited, CNA #7 was observed to wash her hands in the sink located in the Soiled Utility Room.<br><br>On 10/21/13 at 11:30 AM, CNA #7 was interviewed and stated, "I washed my hands in the Soiled Utility Room." When asked when she should have washed her hands, CNA #7 stated, "I should have washed my hands before leaving the | F 441 | | |

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| F 441 | Continued From page 37<br>resident's room."<br><br>The CNA did not wash her hands after changing a resident's brief. She was observed to push the EZ Lift Equipment and pick up the trash bag with contaminated hands. She then opened the door to the Soiled Utility Room and deposited the trash with contaminated hands.<br><br>The facility's Handwashing/Hand Hygiene Policy and Procedure, revised August 2012, documented staff should wash their hands:<br>*"Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice); and,<br>*Before and after assisting a resident with toileting (hand washing with soap and water)."<br><br>On 10/23/14 at 3:50 PM, the Administrator and DON were made aware of the observed infection control concern. No further information was provided by the facility. | F 441 | | |
| F 514<br>SS=E | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>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.<br><br>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. | F 514 | 1. Resident #1's Physician Order Report was updated immediately to reflect current care status. 2. Resident #3's Physician Order Report was updated to reflect current code status. 3. Resident #2's medication recap was updated to reflect current medication usage. 4. Resident #8's treatment flow sheet was | 11/17/14 |

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This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, it was determined the facility failed to maintain accurate, complete, and organized clinical records on each resident. This was true for 4 of 13 (#'s 1-3 and 8) sampled residents reviewed for clinical records. This created the potential for medical decisions to be based on inaccurate information. Findings included:

1. Resident #1 was readmitted to the facility on 5/30/14 with multiple diagnoses including dementia with behavioral disturbances and osteoporosis.

The resident's October 2014 Physician Order Report documented an ordered dated 5/30/14, "Hip Percautions [sic] x [times] 3 months."

On 10/22/14 at 3:10 PM, the Behavior Care Program Coordinator was interviewed regarding the order. When asked why the order was still on the report since the 3 months had already past, she said, "I don't know." However, she did say the order did not make it onto the TAR.

2. Resident #3 was readmitted to the facility on 1/31/13 with multiple diagnoses including late effect of intracranial injury and organic brain syndrome with psychosis.

The resident's October 2014 Physician Order Report documented, "Code Status: Do Not Resuscitate", with an order date of 1/31/13.

The resident's Advance Care Plan dated 5/8/13,

F 514 updated to reflect physicians original orders from 05/19/10.
2. All residents have the potential to be affected. Through admit assessment, quarterly MDS review and prn change of status review residents with physician order changes will be identified.
3. Staff education on Physician Order Recaps was done on 11/4/14. Facility wide chart audits began 11/11/14. Mini in-service on CPAP care and cleaning 11/12/14.
4. Will continue with weekly chart audits for one month and monthly for three months after that. The DNS or designee will follow this issue in QA review and report to the QA committee.

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documented the resident's status was a Full Code.

The resident's Idaho Physician Orders for Scope of Treatment (POST) signed and dated by the resident's guardian on 9/4/14, documented, "Resuscitate (Full Code)."

On 10/22/14 at 3:55 PM, the Behavior Care Program Coordinator was interviewed regarding the status issue. When shown the discrepancy in the medical records, she said staff would follow the code status on the POST. She said the Physician Order Report was inaccurate and would be changed.

3. Resident #2 was readmitted to the facility on 9/20/14 with multiple diagnoses which included dementia with behavioral disturbance, anxiety and psychosis.

The most recent significant change MDS assessment, dated 9/23/14, documented Resident #2 received antianxiety medications 1 day in the previous 7 days from the look back period for the assessment.

An order on a prescription form, dated 8/28/14, documented the order, "Ativan 2 mg/ml...0.5 - 1 mg PO Q [Every] 8 hrs [Hours] PRN severe anxiety."

The September and October 2014 recapitulated Physician's Orders did not include an antianxiety medication for Resident #2.

The September and October 2014 MAR documented the aforementioned Physician's Order for Ativan. Resident #4 received the

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medication 9 times in September and twice in October.

On 10/22/14 at 10:40 a.m., the Behavior Unit Program Manager (BUPM) was asked if Resident #2 was receiving Ativan and she stated, "I don't believe she is anymore. I don't see it on here [recapitulated Physician's Orders]." After futher record review the BUPM stated, "She does take Ativan, it says every 8 hours" on the discharge orders from the local hospital.

On 10/22/14 at 10:50 a.m., LN #8 was interviewed regarding the process for ensuring recapitulated Physician's Orders were all inclusive. The LN stated, "Once a month the ADNS [Assistant Director of Nursing Services] reviews recaps and signs it." The LN noted a star stamped on the prescription form for Ativan and explained the star meant it had been through medical records. After reviewing Resident #2's October 2014 recap orders, the LN stated, "Not on there. Her Ativan was PRN on 8/28/14" and it would not have been on August, but would be in September. After reviewing the September 2014 recap orders, the LN stated, "It's not on there either."

On 10/22/14 at 5:50 p.m., the Administrator and DON were informed of the incomplete recapitulated Physician's Orders. No further information or documentation was provided.

4. Resident #8 was admitted to the facility on 11/15/06 and readmitted on 5/10/10 with multiple diagnoses which included chronic obstructive pulmonary disease (COPD), chronic respiratory failure and obstructive sleep apnea.

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| F 514 | Continued From page 41<br>Review of Resident #8's Physician Order Report for October 2014, documented an order for, "CPAP on at 2100 [9:00 PM] - Sleep Apnea," with a start date of 6/4/10. However, the actual order was dated 5/19/10 and documented, "CPAP at 12 at night and PRN - COPD/Sleep Apnea."<br><br>On 10/23/14 at 11:45 AM, the DON stated, "The settings should be on the recapitulation orders..." The DON then showed the surveyor a copy of the [Name of the facility] Physician's Admission Orders, dated 5/19/10, and stated, "the settings must have dropped off when the order was carried over." | F 514 | | |

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NAME OF PROVIDER OR SUPPLIER: VALLEY VISTA CARE CENTER OF ST MARIES

STREET ADDRESS, CITY, STATE, ZIP CODE: 820 ELM STREET, ST MARIES, ID 83861

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 000 | 16.03.02 INITIAL COMMENTS<br><br>The following deficiencies were cited during the State licensure survey of your facility.<br><br>The surveyors conducting the survey were:<br>Brad Perry, BSW, LSW, Team Coordinator<br>Lauren Hoard RN, BSN<br>Rebecca Thomas, RN | C 000 | | |
| C 124 | 02.100,03,c,viii Confidentiality of Records<br><br>viii. Is assured confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in case of his transfer to another health care facility, or as required by law or third-party payment contract;<br>This Rule is not met as evidenced by:<br>Please refer to F-164 as it relates to privacy of clinical records. | C 124 | See F Tag F-164 | 11/17/14 |
| C 411 | 02.120,05,k All Resident Rooms Numbered<br><br>k. All patient/resident rooms shall be numbered. All other rooms shall be numbered or identified as to purpose.<br>This Rule is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure 5 rooms in the facility were labeled. This had the potential to affect residents or visitors. Findings included:<br><br>On 10/20/14 from 1:50 to 1:55 PM, the following rooms did not have any identification on them:<br>*The Medication room;<br>*A dirty utility room between rooms 212 and 218;<br>*A linen closet next to room 227; | C 411 | 1. Maintenance manager was alerted to the issue and all five rooms were labeled on 10/20/14.<br>2. All residents have the potential to be affected.<br>3. Staff education on state requirements for labeling of all rooms in facility. | 11/17/14 |

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brad Hy
TITLE: NHA
(X6) DATE: 12-10-14

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED |
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| | MDS001820 | | 10/24/2014 |

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| C 411 | Continued From page 1<br>*A storage room between rooms 238 and 240; and,<br>*A maintenance room behind the nurses station.<br><br>On 10/20/14 at 2:13 PM, the Administrator was shown these rooms and he said he would make sure signs were placed on the doors. | C 411 | 4. Maintenance manager will monitor and report findings to Safety Committee starting with November meeting and ongoing. | |
| C 650 | 02.150,01,a,vii Resident Care Practices<br><br>vii. Resident care practices, i.e., catheter care, dressings, decubitus care, isolation procedures.<br>This Rule is not met as evidenced by:<br>Refer to F-315 as it relates to suprapubic catheter care. | C 650 | See F Tag F-315 | 11/17/14 |
| C 664 | 02.150,02,a Required Members of Committee<br><br>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative.<br>This Rule is not met as evidenced by:<br>Based on staff interview and review of Infection Control Committee (ICC) meeting attendance records, it was determined the facility failed to ensure the Maintenance Representative and Pharmacist attended/participated in quarterly ICC meetings. This failure created the potential for a negative affect for all residents, staff, and visitors in the facility when ICC members were not involved in the ICC meetings. Findings included:<br><br>On 10/23/14 at 9:05 a.m., LN #5, who was the designated Infection Control Nurse, was interviewed about the Infection Control Program. | C 664 | 1. Staff was immediately educated and maintenance manager and pharmacist were alerted to state requirements for Infection Control Committee.<br>2. All residents have the potential to be affected.<br>3. Maintenance manager and pharmacist will be present at ICC meetings no less than every quarter per state regulation. | 11/17/14 |

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| C 664 | Continued From page 2<br><br>The LN was asked to show attendance records for 4 consecutive months of ICC meetings.<br><br>The attendance records documented the staff who attended the aforementioned ICC meetings, but the Pharmacist and Maintenance Representative were not on the list. When asked if the Pharmacist attended the ICC meetings at least quarterly, she stated, "He never comes in." When asked if the Maintenance Representative attended the ICC meetings at least quarterly, the LN stated, "No."<br><br>On 10/23/14 at 3:50 p.m., the Administrator and DON were informed of the ICC meeting attendance issue. No further information or documentation was provided. | C 664 | 4. DNS or designee will schedule the infection control committee meetings so that the maintenance manager and pharmacist can be in attendance starting with our next scheduled meeting on 11/17/14. DNS or designee will monitor and report findings to Safety Committee. | |
| C 745 | 02.200,01,c Develop/Maintain Goals/Objectives<br><br>c. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals;<br>This Rule is not met as evidenced by:<br>Please refer to F-281 as it relates to professional services. | C 745 | See F Tag F-281 | 11/17/14 |
| C 778 | 02.200,03,a PATIENT/RESIDENT CARE<br><br>03. Patient/Resident Care.<br><br>a. A patient/resident plan of care shall be developed in writing upon admission of the patient/resident, which shall be:<br>This Rule is not met as evidenced by:<br>Please refer to F-279 as it relates to care plans. | C 778 | See F Tag F-279 | 11/17/14 |

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| C 782 | 02.200,03,a,iv Reviewed and Revised<br><br>iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished;<br>This Rule is not met as evidenced by:<br>Please refer to F-280 as it relates to care plan revisions. | C 782 | See F Tag F-280 | 11/17/14 |
| 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>Refer to F323 supervision and/or assistive devices to prevent falls. | C 790 | See F Tag F-323 | 11/17/14 |
| C 820 | 02.201,01,a 30-Day Review of All Meds<br><br>a. Reviewing the medication profile for each individual patient at least every thirty (30) days. The attending physician shall be advised of drug therapy duplication, incompatibilities or contraindications.<br><br>This Rule is not met as evidenced by:<br>Please refer to F-329 as it relates to duplicate therapy. | C 820 | See F Tag F-329 | 11/17/14 |
| C 821 | 02.201,01,b Removal of Expired Meds<br><br>b. Reviewing all medications in the facility for expiration dates and shall be responsible for the removal of discontinued or expired drugs from use as indicated at least every ninety (90) days. | C 821 | See F Tag F-431 | 11/17/14 |

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| C 821 | Continued From page 4<br><br>This Rule is not met as evidenced by:<br>Please refer to F-431 as it relates to expired medications. | C 821 | | |
| C 832 | 02.201,02,f Labeling of Medications/Containers<br><br>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.)<br><br>This Rule is not met as evidenced by:<br>Please refer to F-431 as it relates to medication labels. | C 832 | See F Tag F-431 | 11/17/14 |
| C 881 | 02.203,02 INDIVIDUAL MEDICAL RECORD<br><br>02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following:<br>This Rule is not met as evidenced by:<br>Refer to F514 regarding medical records accuracy. | C 881 | See F Tag F-514 | 11/17/14 |