



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7012 1010 0002 0836 2021

December 2, 2013

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

Provider #: 135075

Dear Mr. Sawyer:

On **November 7, 2013**, we conducted an on-site follow-up revisit to verify that your facility had achieved and maintained compliance. We had presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **September 16, 2013**. However, based on our on-site follow-up revisit conducted **November 7, 2013**, we found that your facility is not in substantial compliance with the following participation requirements:

- F226 -- S/S: D -- 42 CFR §483.13(c) -- Develop/Implment Abuse/Neglect, Etc Policies**
- F280 -- S/S: D -- 42 CFR §483.20(d)(3), 483.10(k)(2) -- Right to Participate Planning Care - Revise CP**
- F314 -- S/S: D -- 42 CFR §483.25(c) -- Treatment/Services to Prevent/Heal Pressure Sores**

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. **WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. Please provide ONLY ONE completion date for each federal and state tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance.** After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form

Brian V. Sawyer, Administrator
December 2, 2013
Page 2 of 4

CMS-2567 and State Form, in the spaces provided and return the originals to this office.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 16, 2013**.

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

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

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

Brian V. Sawyer, Administrator
December 2, 2013
Page 3 of 4

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

On **September 18, 2013**, the Centers for Medicare and Medicaid Services (CMS) notified you of imposition for Denial of Payment for New Admissions effective **November 16, 2013**, and termination of the provider agreement on **February 16, 2014**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

STATE ACTIONS effective with the date of this letter (**December 2, 2013**): none

If you believe the deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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

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

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

- BFS Letters (06/30/11)
• 2001-10 Long Term Care Informal Dispute Resolution Process

Brian V. Sawyer, Administrator
December 2, 2013
Page 4 of 4

2001-10 IDR Request Form

This request must be received by **December 16, 2013**. If your request for informal dispute resolution is received after **December 16, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the on-site follow-up revisit. If you have any questions or concerns, please contact this office at (208) 334-6626.

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser". The signature is written in a cursive, slightly slanted style.

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

LKK/dmj
Enclosures

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

PRINTED: 12/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/07/2013
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CTR 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) COMPLETION DATE	
{F 000}	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the follow-up revisit survey of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Linda Kelly, RN, Team Coordinator Karen Marshall, MS, RD, LD</p> <p>The survey team entered the facility on 11/6/13 and exited the facility on 11/7/13.</p> <p>Survey Definitions: ADL = Activities of Daily Living ADNS = Director Nursing Services BIMS = Brief Interview for Mental Status CAA = Care Area Assessment CNA = Certified Nurse Aide DNS/DON = Director Nursing Services/Director of Nursing LN = Licensed Nurse MDS = Minimum Data Set assessment PRN = As Needed TAR = Treatment Administration Record</p> <p>F 226 483.13(c) DEVELOP/IMPLMENT SS=D ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of Resident Incident Reports, record review, and staff interview, it was</p>	{F 000}	<p>Preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because the provisions of the Federal and State laws require it. This provider does not maintain that the alleged deficiencies do not individually, or collectively, jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the provider asserts that it is in substantial compliance with regulations governing the operation and licensure of long term care facilities, and this Plan of Correction, in its entirety, constitutes this providers allegation of compliance.</p> <p>Completion dates are provided for the procedural procession purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in compliance with requirements of participation or that corrective action was necessary.</p>		

RECEIVED
DEC - 6 2013
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Bruan V. Sawyer NHA* TITLE *12/4/13* (X6) DATE

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.

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

PRINTED: 12/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/07/2013	
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CTR 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) COMPLETION DATE
F 226	<p>Continued From page 1</p> <p>determined the facility failed to ensure all injuries of unknown origin were investigated. This was true for 1 Resident Incident Report reviewed for Resident #18. Failure to investigate an injury of unknown origin placed the resident at risk for abuse. Findings included:</p> <p>Resident #18 was most recently admitted to the facility on 7/9/11 with multiple diagnoses which included Alzheimer's dementia, dementia with behavioral disturbances, idiopathic peripheral autonomic neuropathy, osteoarthritis, chronic pain, and chronic dermatitis and pruritus.</p> <p>The resident's most recent quarterly MDS assessment, dated 8/23/13, coded, in part:</p> <ul style="list-style-type: none"> * Severe cognitive impairment, with a BIMS score of 4; * Extensive assistance by 2 or more people for most activities of daily living; * Total assistance by 2 or more people for bathing; * Functional limitation in range of motion in both lower extremities; and, * At risk for pressure ulcers. <p>A one page Resident Incident Report, dated 10/24/13, for the resident included the following documentation:</p> <ul style="list-style-type: none"> * Ambulatory status prior to incident: Non-ambulatory, wheelchair use; * Describe what happened: "CNA...called LN to assess wound on (R) foot on lateral side of 5th toe [with] cleansing, between 4th [and] 5th toe. Injury appears as an appx [approximately] 0.2 cm [centimeter] depth by 0.6 x [by] 1.3 cm area. Wound bed [with] hard dark exudate vs. [versus] slough." * Type of injury: Not documented; 	F 226	<ol style="list-style-type: none"> 1. Our wound care nurse and nurse practitioner assessed the residents wound. Both classified it as vascular in origin. Treatment was initiated. ✓ 2. All residents have the potential to be affected. A new process was implemented to assure proper documentation of root cause for accidents and incidents. ✓ 3. In- servicing done for nursing staff on accident training, prevention, documentation and management beginning on 11/12/13 and ongoing. IDT will discuss all investigations weekly beginning 11/19/13 at the PAR meeting x 4 weeks, then monthly x 3 months. ✓ 4. The DNS or her designees will follow this issue in QA review as stated above and report monthly to the QA committee beginning with the November QA meeting. ✓ 	<p>ADMIN 12.13.13 11:33AM KM</p> <p>DNS</p> <p>12/16/13</p>

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

PRINTED: 12/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/07/2013
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CTR 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) COMPLETION DATE	
F 226	Continued From page 2 * Findings: Not documented; * Action taken: Not documented; and * Reviewed by: ADNS 10/25/13. On 10/7/13 at 9:15 a.m., the Administrator was asked to provide the investigation of the 10/24/13 incident report for Resident #18. The Administrator referred the surveyor to the DNS. On 10/7/13 at 9:30 a.m., the DNS was asked to provide the investigation of the 10/24/13 incident report for Resident #18. The DNS stated she was on vacation at that time and, "The ADNS should have completed the investigation, but she says she did not." No other information or documentation was received from the facility which resolved the issue.	F 226			
{F 280} SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. 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	{F 280}	1. Resident # 19 had care plan adjustments made to identify special mobility needs. ✓ 2. All residents have the potential to be affected. A house wide audit was performed to update special care planning needs. Through admit assessment, quarterly MDS review and prn change of status review residents will be identified for care planning needs as they relate to personal preferences. ✓		

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

PRINTED: 12/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/07/2013
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CTR 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)
{F 280}	<p>Continued From page 3 and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interviews, it was determined the facility failed to update a resident's care plan for wheeling a resident backwards while seated on the platform of the resident's 4-wheeled walker (4WW). This affected 1 of 3 (random resident #19) sampled for care plan revision. This practice created the potential for the resident to receive inappropriate care due to lack of direction in the care plan. Findings included:</p> <p>Resident #19 was originally admitted to the facility on 3/26/13 and readmitted on 7/9/13 with multiple diagnoses including aftercare for traumatic fracture of right hip, difficulty walking, and history of falls.</p> <p>The resident's 10/2/13 quarterly MDS coded moderately impaired cognitive skills, no delirium, walking in room and corridor required one person limited assistance, locomotion on and off unit required one person extensive assistance, balance during transitions was unsteady but was able to stabilize without human assistance, walking did not occur, lower extremity impairment, and mobility device was a walker.</p> <p>The resident's Care Plan, dated 10/2/13, identified the ADL functioning problem, "monitor need for Assist [assistance]." The subsection transfer documented, in part, "sits on 4WW</p>	{F 280}	<p>3. In servicing was held for nursing staff on special care planning needs beginning on 11/12/13 and ongoing.</p> <p>Weekly QA rounds for 4 weeks and then monthly for 3 months beginning on 11/12/13.</p> <p>4. The DNS or her designee will follow this issue in QA review as stated above and report monthly to the QA committee beginning with the November QA meeting.</p> <p><i>Admin</i> 11:33 am 12-13-13 KM DNS 12/16/13</p>

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

PRINTED: 12/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/07/2013
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CTR 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) COMPLETION DATE	
{F 280}	<p>Continued From page 4</p> <p>[4-wheeled walker], check for need of assist..." The subsection ambulation mobility documented, in part, "...sits on seat of 4WW...Indep [independent with] 4WW..."</p> <p>On 11/6/13, the following was observed and interviews were obtained as follows:</p> <p>At 12:05 p.m., two surveyors observed CNA #1 wheel the resident backwards from the behavior unit nurses station through the dining activity area to the resident's room. The resident was seated on the platform seat of a 4WW. The resident and the CNA were conversing in what appeared to be normal conversation as the CNA wheeled the resident to her room.</p> <p>At 12:08 p.m., the surveyor informed the Behavior Care Program Manager (BCP Manager) of the observation. The BCP Manager stated, "As a rule, we do not push residents backwards. Sometimes [Resident #19] will not let us push her forward when we try to assist her." The surveyor asked the Manager if the resident's care plan included the resident would not allow staff to push her forward. The Manager indicated, "It may not be [care planned]."</p> <p>At 12:10 p.m., the surveyors spoke with CNA #1. The CNA stated, "[Resident #19] will not let us push her forward and it's care planned for her to be pushed backwards. She was coming back from smoking." The CNA then explained to the surveyors how the resident would come out of her room and then stop at certain areas in the dining activity area and staff would have to help the resident with mobility.</p> <p>At 12:35 p.m., the surveyor spoke with the</p>	{F 280}			

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

PRINTED: 12/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/07/2013
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CTR 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) COMPLETION DATE	
{F 280}	Continued From page 5 resident about CNA #1 pushing her backward while seated in the 4WW. The resident stated, "I do not care. What is the difference?" On 11/7/13 at 11:05 a.m., the surveyor again spoke with the BCP Manager. The Manager stated, "I updated the resident's care plan yesterday with how resident self propels." The surveyor and the Manager reviewed the resident's care plan. The care plan did not address staff wheeling the resident backwards while the resident sat on the platform seat of the 4WW. The Manager reviewed the care plan and made a handwritten update, "Staff may assist resident with wheeled walker backwards per resident choice." On 11/7/13 at 11:32 a.m., the survey team informed the Administrator, DON, BCP Manager, Administrator in Training, Corporate Compliance Director, Corporate Compliance RN, Resident Service Coordinator, and the Human Resource Director of the finding. On 11/8/13, the facility provided additional information related to the staff wheeling the resident backwards while seated in the 4WW. The information did not resolve the concern the resident's care plan did not include the intervention of wheeling the resident backwards while seated on the platform seat of her 4WW.	{F 280}			
{F 314} SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the	{F 314}	1. Resident #18 was seen by NP and Wound Nurse on 11/7/13. An assessment of the wound was done and it was determined that this was a mixed etiology ulcer, and the plan of care was		

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

PRINTED: 12/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/07/2013
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CTR 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)
{F 314}	<p>Continued From page 6</p> <p>individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure residents without pressure ulcers (PUs) did not develop pressure ulcers. This was true for 1 of 4 residents (#18) reviewed for pressure ulcers. Failure to recognize pressure as a contributing factor related to a left thumb joint skin problem, to notify the physician timely and to revise the care plan to include the left thumb joint skin problem, created the potential for more than minimal harm should the facility fail to implement appropriate preventive measures related to the resident's risks, level and nature of risk, or presence of PUs. Findings included:</p> <p>Note: The facility was cited at F 314, Pressure Ulcers, during the annual survey conducted 8/16/13.</p> <p>Resident #18 was most recently readmitted to the facility on 7/9/11 with multiple diagnoses which included: Alzheimer's dementia; osteoarthritis (OA), multiple sites; contractures of the knees/hips; chronic stasis and contact dermatitis; and, chronic pruritis.</p> <p>The resident's PU CAA, dated 5/31/13, included the following documentation: * "Treatments and other factors that cause complications or increase risk[:] Functional</p>	{F 314}	<p>appropriate and this skin concern was unavoidable.</p> <p>2. All residents have the potential to be affected. Through assessment using the Braden Scale on admit, quarterly and prn change residents at risk will be identified. All current residents who are high risk for skin break down were reviewed by facility wound care nurse and the IDT team on 11/18/13. All applicable changes or care plan updates were done.</p> <p>3. In-servicing done for nursing staff on wound and skin care prevention and treatment beginning on 11/12/13 and ongoing. Referrals made to NP Wound and Skin Nurse. Routine bi-monthly visit were initiated for rounding and education by the NP and Wound nurse for 90 days and at least monthly thereafter. Investigations into all skin issues were initiated and will be monitored by the facilities Wound nurse and will be reviewed by IDT weekly. Weekly QA rounds for 4 weeks and then monthly for 3</p> <p><i>admin 12.13.13 11:33AM DMSaw WN</i></p>

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

PRINTED: 12/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/07/2013
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CTR 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) COMPLETION DATE
{F 314}	<p>Continued From page 7 limitation in range of motion...limited use of his left shoulder and arm..."</p> <p>* Analysis of Findings - "PROBLEM: potential for [PU]. CAUSES/CONTRIBUTING FACTORS: ...DJD [degenerative joint disease] with pain...chronic dermatitis[.] RISK FOR: skin breakdown/pressure ulcer...Current Care plan reviewed...no changes...assist in minimizing the potential for [PU] as per cause/contributing factors listed...and to lessen or prevent the risk factors listed...if [PU] do occur with an overall goal of prevention and effective treatment of [PU]."</p> <p>The resident's most recent quarterly MDS assessment, dated 8/23/13, coded, in part: * Severe cognitive impairment, with a BIMS score of 4; * Rejection of cares 4-6 days during the look back period, but less than daily; * Extensive assist of 2 or more people for most activities of daily living; * Functional limitation in range of motion in both lower extremities; * At risk for pressure ulcers (PU); * No unhealed PU/venous or arterial ulcers/other ulcers, wounds, skin problems/other skin problems (included moisture associated skin damage); and, * Application of ointments/medications other than to feet.</p> <p>Review of the facility's Weekly Skin Impairment List (WSIL) audits, dated 9/16/13, 9/19/13, 9/25/13, 10/3/13, 10/10/13, 10/17/13, 10/24/13, and 11/4/13 documented an open area between the resident's left thumb and 2nd finger initially; then on 10/17, an open area on the left inner thumb at the joint.</p>	{F 314}	<p>months beginning on 11/12/13. Patient at Risk review weekly beginning on 11/12/13.</p> <p>4. The DNS or her designee will follow this issue in QA review as stated above and report monthly to the QA committee beginning with the November QA meeting.</p>	12/16/13

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

PRINTED: 12/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/07/2013
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CTR 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) COMPLETION DATE	
{F 314}	Continued From page 8 The WSIL audits included resident names, the skin problem, location, stage, and treatment for the problem. The audits asked if the skin problem was healing and if the care plan was current. The audits also included an area for comments. The WSIL audits noted the following skin problems for Resident #18: * 9/16 - Skin Problem: "Open area caused by contractions." Location: "L [left] hand, between thumb & 2nd finger." Stage: "n/a [not applicable]." Treatment, "Daily cleanse w[with]/Vashe solution, gauze to protect and eliminate skin-to-skin contact. Inflatable posey placed 9/13/13..." Healing? "Yes." Care plan current? "Yes." Comments: "Fungal component-using antifungal powder after each cleanse." * 9/19 and 9/25 - Essentially the same as above, except: "Comments: No open areas at this time. Will continue w/daily cleanse and inflatable posey." * 10/3 and 10/10 - Essentially the same as above. * 10/17 - A new skin problem was identified as "Open area caused by contractions[;] Location: Left thumb at joint, inner aspect[;] Stage: n/a[;] Treatment Vashe cleanse, cover w/gauze/ Place inflatable Posey[;] Healing? New[;] Care Plan Current? Yes" and, "Comments: Daily assessment with placement of posey." * 10/24 - Same as above, except: "Healing? No" and "Comments: Daily assessment with placement of posey by LN [licensed nurse]." * 11/4/13 - Same as above, except: "Treatment Vashe cleanse, cover w/gauze. Place inflatable Posey. BID [2 times a day]" and "Comments: Daily assessment with placement of posey by LN. Will discuss with IDT [interdisciplinary team]...next week."	{F 314}			

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

PRINTED: 12/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/07/2013
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CTR 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) COMPLETION DATE	
{F 314}	<p>Continued From page 9</p> <p>The care plan in the resident's chart directed the reader to the Skin Impairment/Pressure Ulcer Care Plan folder at the nurses' station.</p> <p>The resident's skin/PU care plan located at the nurses' station and "Printed: 6/5/13," included the following documentation:</p> <ul style="list-style-type: none"> * "Problem: 10 Skin Impairment/Pressure Ulcer Care Plan-See Skin Care Folder at Nursing Station. * Related to: ...OA/DJD [degenerative joint disease]...chronic stasis dermatitis, chronic pruritis, Hx [history] of non compliance to pressure relief measures. * Exhibited by: ...Pain and contractures of knees/impaired mobility...Confusion and behaviors/resistant to cares... * Interventions: Frequency/Duration Resolved Disc[cipline] 1 See ADL care plan for individual interventions 2 Please monitor & implement for the following pressure ulcer prevention interventions daily on your shift: NDE [nights, days, evenings]...8...Pad bony prominences with pillows...11 Contact dermatitis bilateral arms with treatment pm [as needed]; see TAR- (refused several attempts of consult appointments with dermatologist)..." <p>This care plan did not include anything about the open area at the left inner thumb joint.</p> <p>On 11/6/13 at 3:20 p.m., the facility's wound nurse (WN), was interviewed. When asked about the open area on the resident's left thumb joint, the WN stated, "It started as a fungal infection in the palm that resolved and moved to the web between the thumb and forefinger." Then the WN stated, "It was not the palm. It was the webbing."</p>	{F 314}			

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

PRINTED: 12/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/07/2013
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CTR 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) COMPLETION DATE	
{F 314}	<p>Continued From page 10</p> <p>When asked if a doctor had assessed the area, the WN stated, "I don't know if [physician's name] ever looked at it." When asked who determined it was a fungal infection, the WN stated, "Me." The WN informed the surveyor that the physician had assessed the resident's left thumb that day. The WN stated, "He thinks the splint is causing pressure" and that the physician discontinued the splint that day. When asked if she had considered pressure as the cause, or a contributing factor to the resident's left thumb joint skin problem, the WN stated, "No." When asked about the care plan for the left thumb joint skin problem, the WN stated that she would have completed a temporary care plan and the temporary care plan would have "gone away" when the problem resolved; or, it would have been added to the on-going care plan. When asked if the problem had gone away, the WN stated, "No." The WN reviewed the resident's skin/PU care plan and confirmed that the left thumb joint skin problem was not included in the care plan at the nurses' station or in the resident's chart. The WN stated that the skin/PU care plan "was for pressure ulcers only."</p> <p>On 11/6/13 at 4:05 p.m., 2 surveyors accompanied the WN to the resident's room. The resident's left fingers were observed to be contracted with the inner aspect of the distal interphalangeal (DIP) joint of the thumb (1st finger) pressed against the side of medial interphalangeal (MIP) joint of the 3rd finger. When the WN opened the resident's left hand, an intact blackish circular area, about 1.5 centimeters (cm) in diameter, was observed on the inner aspect of the DIP joint of the thumb.</p> <p>On 11/7/13 at 8:35 a.m., the surveyor</p>	{F 314}			

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

PRINTED: 12/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/07/2013
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CTR 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) COMPLETION DATE
{F 314}	<p>Continued From page 11</p> <p>accompanied the WN to the charting room where the WN looked for a temporary skin care plan for Resident #18. However, she did not find one. When asked how the thumb joint skin problem was tracked, or documented, the WN said, "In nurses' notes and the TAR." The WN stated she would use wound tracking sheets, "For the ones that are more severe." When asked if any wound tracking sheets were used regarding the resident's left thumb joint skin problem, the WN stated, "No."</p> <p>Interdisciplinary Progress Notes (IPN) dated 6/26/13 through 11/6/13 documented:</p> <ul style="list-style-type: none"> * 7/9/13 "NSG [nursing] ...aides reported open to the resident's left hand. * 7/10 - "O.T. [occupational therapist] "...unable to open his fingers or move his wrist...Do not recommend O.T...Spoke to wound RN [registered nurse] and we agreed daily skin care, dressing on his wound changed daily, and a soft splint in his hand to prevent further fingernail damage to the palmer surface of his left hand." * 7/10 - "Wound care: impairment to (L) [left] hand [at] area between thumb and index finger: open area...[without] drng [drainage] [without] S/S [signs/symptoms] of infection..." * 7/11 at 10:45 a.m. - "NSG ...Web of thumb/forefinger [with] open area...Wound margin distinct, [without] maceration...posey soft hand splint placed..." * 7/16 at 10:45 a.m. - "NSG ...dressing in place to left hand, superficial abrasion noted superior to dressing..." * 7/17 "Wound care: skin impairment to tissue between thumb/index finger (L) hand-resolving...pain [with] trying to open thumb to visualize wound [secondary to] severe contracture." 	{F 314}		

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

PRINTED: 12/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/07/2013
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CTR 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) COMPLETION DATE	
{F 314}	Continued From page 12 * 8/5 - "Wound care: area of skin impairment to webbing between thumb/index finger (L) hand: [No] yeasty odor noted, splint in place. Scant amt [amount] of tan drng...Fingers, hand severely contracted..." * 8/14 - "Wound care: ...open area measures approx[imately] 1 x [by] 0.4 x 0.1 cm [with] foul odor, dried sang[ui]nous drng...Cleansed...placed Alginate to open area, secured [with] gauze wrap to keep fingernails from digging into skin [secondary to] contractures. Soft splint replaced..." * 8/21 at 9:30 a.m. - "NSG...wound assessment to (L) hand between thumb and 2nd finger. [No] odor present. Contractures tight...Posey placed in hand to keep fingernails from causing further damage. To clarify: suspect initial breakdown d/t [due to] increased contractures [and] fingernails breaking the skin. Because of moist status, fungal component to wound came into play = use of antifungal powder..." * 8/23 at 9:30 a.m. - "NSG...Left hand contracted, dressing change x 1 to wound [at] underside of thumb proximal to hand..." * 8/24 at 11:50 a.m. - "NSG...Area between thumb et [and] index finger fragile pink tissue [No] open area. Seen [sic] joints cont[inue] to be very contracted..." * 8/25 at 9:40 a.m. - "NSG...Pinpoint scab covering previous open area..." * 9/4 at 11:30 a.m. - "NSG OT assessed for a splint/posey that may [increase] air flow by opening contracted fingers..." * 9/6 at 7:30 a.m. - "NSG...resolving skin lesion to underside of thumb..." * 9/7 at 9:00 a.m. - "NSG...(L) thumb area [no] open area Scab in place..." * 9/9 at 7:30 a.m. - "NSG...left hand contracted...new gauze placed [at] site of left	{F 314}			

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

PRINTED: 12/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/07/2013
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CTR 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) COMPLETION DATE
{F 314}	<p>Continued From page 13</p> <p>thumb..."</p> <p>* 9/11 at 10:45 a.m. - "NSG...Left hand contracted [with] dry patch at skin to inner aspect of thumb, skin intact..."</p> <p>* 9/13 at 9:30 a.m. - "NSG...New DeRoyal hand pump in place..."</p> <p>* 10/2 at 6:45 a.m. - "NSG...Sm[all] purple/reddened area to thumb. Skin intact. Antifungal powder applied [with] clean hand posey."</p> <p>* 10/9 "Wound care: (L) hand: [No] open area...Will continue [with] inflatable posey..."</p> <p>* 10/16 at 8:30 a.m. - "NSG...[No] fungal odor noted. Open area to (L) thum [sic] [at] joint...Open area ~ [about] 0.5 x 0.8 cm. TAR [changed] to cleanse [with] Vashe again [and] protect from skin [to] skin contact."</p> <p>* 10/23 "Wkly [weekly] wound care...: L thumb [with] open circular macerated area [with] fungal odor. 0.5 cm circular [at] joint...nonadherent gauze to prevent skin [to] skin contact. Placed inflatable posey in palm..."</p> <p>* 10/25 at 9:45 p.m. - "NSG...(L) thumb [with] open area..."</p> <p>Note: None of the remaining IPN contained any documentation regarding the resident's left thumb joint skin problem.</p> <p>* 11/6 at 10:10 a.m. - "Seen by PCP [primary care provider] on rounds. See N.O. [new order].</p> <p>There was never a definitive diagnosis regarding a fungal infection to the resident's left hand and the resident was known to have contractures of the left fingers. However, the WN stated that she never considered pressure from the resident's own fingers or the splints used to open the fingers as a contributing factor to the skin problem over the left thumb joint, a bony prominence. In addition, the resident's care plan was never</p>	{F 314}		

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

PRINTED: 12/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/07/2013
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CTR 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) COMPLETION DATE	
{F 314}	Continued From page 14 updated, or revised, to include the skin problem at the left thumb joint. On 10/7/13 at 11:30 a.m., the Administrator, Administrator in Training, DNS, Corporate Compliance Director, and Corporate Compliance Nurse were informed of the finding. On 10/8/13 at 1:52 p.m., a 15 page facsimile [fax] was received from the facility. This fax included "Additional information regarding F 314" with a narrative; IPN dated 9/2 through 10/25/13; an 11/7/13 Progress Note by a Certified Wound Care Nurse, Nurse Practitioner; Physician Orders; and, Physician Order Flow Sheets for Resident #18. The narrative included, "On 10/9/13 the skin nurse re-assessed his left hand and felt since there were no open areas we would discontinue the vashe cleanse and charting but continue with the soft inflatable posey to his left hand to keep increased air flow... Then, on 10/16/13 the skin nurse re-assessed the left hand and noted a very small...red open area at the left thumb joint. While this was not clearly documented in the 10/16/12 NN [nurses' notes], she said it was just under the joint (vs. right over the top of it.). Since Resident #18 had just gotten over the fungal infection that was in the webbing directly under the left thumb joint, she believed this may be a reoccurrence of the fungus. Further, she stated in her note to "protect from skin to skin contact" because she felt there was increased moisture, which contributes to fungal growth. The floor nurses continued the treatment on the TAR. Then, on 10/23/13 the skin nurse re-assessed the wound and noted a "macerated" open area on the joint	{F 314}			

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

PRINTED: 12/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/07/2013
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CTR 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) COMPLETION DATE	
{F 314}	Continued From page 15 that had a fungal odor." It was cleaned and re-dressed... Then the inflatable posey was placed. On 11/5/13, the skin nurse felt the wound was getting worse and had too much moisture. We discussed this in depth at the weekly Patient at Risk Meeting... She [skin nurse] had planned to contact [Nurse Practitioner's name]... However, before she could do that, the resident's primary physician was in to see him on 11/6/13. ...he went ahead and assessed the wound himself. He felt it was pressure related and discontinued the splint. Further, he ordered Silvadene and also ordered a wound consult from [Nurse Practitioner's name]. [Nurse Practitioner's name] saw the resident on 11/7/13. In her Progress Note, she wrote, "...mixed etiology pressure ulcer to L thumb: Moisture-associated dermatitis with pressure - unstageable (will probably reveal as a stg [stage] II or III). ...Unavoidable pressure related to moisture + pressure + fungus. ... Last, while the primary physician did feel it was pressure related the Nurse Practitioner (who specializes in wounds) stated this was a mixed etiology wound that was unavoidable and had been treated appropriately. She re-ordered the splint and the antifungal powder." The additional information did not resolve the issue.	{F 314}			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/07/2013
--------------------------------------------------	----------------------------------------------------------------------------	--------------------------------------------------------------------	----------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CTR 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 The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the follow-up revisit survey of your facility. The surveyors conducting the survey were: Linda Kelly, RN, Team Coordinator Karen Marshall, MS, RD, LD	{C 000}		
C 175	02.100,12,f Immediate Investigation of Incident/Injury f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Refer to F 226 as it related to investigation of accidents and injuries.	C 175	See F 226	12/16/13
C 747	02.200,01,e Individualized Resident Care Plan e. Observing and evaluating the condition of each patient/resident and developing a written, individualized patient care plan which shall be based upon an assessment of the needs of each patient/resident, and which shall be kept current through review and revision; This Rule is not met as evidenced by: Refer to F 314 as it related to care plan revisions regarding skin problems/pressure ulcers.	C 747	See F 280	12/16/13

RECEIVED
DEC - 6 2013
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Brian V. Sawyer</i>	TITLE <i>NNA</i>	(X6) DATE <i>12/4/13</i>
---------------------------------------------------------------------------------------------------------------------------------	---------------------	-----------------------------

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/07/2013
--------------------------------------------------	---------------------------------------------------------------------	-------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CTR 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 781 C 781	Continued From page 1 02.200,03,a,iii Written Plan, Goals, and Actions iii. Written to include care to be given, goals to be accomplished, actions necessary to attain the goals and which service is responsible for each element of care; This Rule is not met as evidenced by: Please refer to F280 as it related to not updating a resident's care plan.	C 781 C 781		
{C 789}	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F 314 as it related to pressure ulcers.	{C 789}	See F314	12/10/13