



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 5914**

December 4, 2014

Scott Burpee, Administrator  
Bell Mountain Village & Care Center  
706 South Main Street  
Hailey, ID 83333-8400

FILE COPY

Provider #: 135069

Dear Mr. Burpee:

On **November 19, 2014**, a Complaint Investigation survey was conducted at Bell Mountain Village & Care Center 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) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

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return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 17, 2014**. Failure to submit an acceptable PoC by **December 17, 2014**, may result in the imposition of civil monetary penalties by **January 6, 2015**.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **December 24, 2014 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **December 24, 2014**.

A change in the seriousness of the deficiencies on **December 24, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December**

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24, 2014 includes the following:

Denial of payment for new admissions effective **February 19, 2015**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **May 19, 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, they 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.I.D.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, Option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **November 19, 2014** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

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- 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 **December 17, 2014**. If your request for informal dispute resolution is received after **December 17, 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.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626, Option 2.

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.I.D.P., Supervisor  
Long Term Care

LKK/dmj  
Enclosures

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

PRINTED: 12/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 11/19/2014
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NAME OF PROVIDER OR SUPPLIER  BELL MOUNTAIN VILLAGE & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 708 SOUTH MAIN STREET HAILEY, ID 83333
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were: Arnold Rosling, RN, BSN, QIDP Lorraine Hutton, RN</p> <p>The survey team entered the facility on November 12, 2014 and exited on November 19, 2014.</p> <p>Survey Definitions: ADL = Activities of Daily Living AIT = Administrator in Training BID = Twice a Day BIMS = Brief Interview for Mental Status BFS = Bureau of Facility Standards/State Survey Agency cm = Centimeters CNA = Certified Nurse Aide DON/DNS = Director of Nursing/Services L = liter LN = Licensed Nurse MAR = Medication Administration Record ml = Milligram MDS = Minimum Data Set assessment PO = By Mouth PRN = As Needed RHIT = Registered Health Information Technician RN = Registered Nurse</p>	F 000		
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an</p>	F 157		

RECEIVED  
FEB 20 2015  
FACILITY COMPLIANCE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE CEO	(X6) DATE 1-26-15
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any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the physician and family was immediately notified of a resident who eloped and fell in the snow. This was true for 1 of 8 (#1) sampled residents. Failure to notify the physician and family created the potential for a lack of evaluation, treatment and/or comfort to the resident. Findings include:</p>	F 157	<p><b>F-157 Notify of Changes (injury/decline/room, etc.)</b></p> <ul style="list-style-type: none"> <li>• What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice <ul style="list-style-type: none"> <li>○ Resident #1's chart was reviewed: and verified contact information for all parties involved was updated. Resident 1 was also evaluated for cognitive changes and continued need for supervision: Wander guard devices continue to remain in place.</li> </ul> </li> <li>• How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective actions(s) will be taken <ul style="list-style-type: none"> <li>○ All Residents with potential for elopement due to cognitive deficits have been identified via the BIMS reports generated by the MDS process.</li> <li>○ All future Accidents, Incidents and Unusual Occurrences will be reported</li> </ul> </li> </ul>	12/23/14	

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F 157	<p>Continued From page 2</p> <p>Resident #1 was admitted to the facility on 6/6/12 with diagnoses of dementia, malaise and fatigue, kyphosis, spinal stenosis and depressive disorder.</p> <p>The most recent quarterly MDS, dated 8/14/14, documented the resident had severely impaired cognition with a BIMS score of 4 and required extensive assistance of one to two staff for transfers, dressing, eating, personal hygiene and bathing.</p> <p>According to an incident report, the resident was found outside the facility front door, at the end of the ramp, on her knees in the snow on 1/26/14 at 6:30 PM. The report had multiple typographical errors including that the family was notified on 1/26/14 at 8:30 AM, which was prior to the incident. There was no other date or time to indicate when the family was actually notified of the incident. The physician was notified on 1/27/14 at 9:31 AM, fourteen hours after the resident was found in the snow.</p> <p>An LN note on 1/27/14 at 10:18 AM documented, "Late entry from 1/26/14 1930 [7:30 PM]. Resident attempted elopement. While performing duties I heard the word 'Help'. I recognized the voice and went to the dining room thinking it was from [Resident #1]. I asked staff where she was. It was indicated to me she had independently removed herself from dining room. I then received assistance from CNA in locating her. I immediately came down the hall while [the] CNA looked in residents room[.] I went to TV room then looked outside. Resident had opened both doors ambulated down w/c [wheelchair] ramp and was on her knees in the snow. her hands were not in the snow. I asked if she could move her</p>	F 157	<p>to the physician, family and administration per Policy and Procedure within appropriate time frames.</p> <ul style="list-style-type: none"> <li>• What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur <ul style="list-style-type: none"> <li>○ The "Notification of Resident Changes" Policy and Procedure and "Accidents, Incidents and Unusual Occurrence Recording and Reporting" Policy and Procedure were in-serviced to the nursing staff by the Administrator and the DNS on 12/9/14 with emphasis on the proper notification of family and physicians.</li> <li>○ Daily reporting of all Unusual Occurrences will be presented at each shift change on the 24 hour report, and each morning. The Administrator, DNS and Medical Director met to clarify the current physician on-call procedure. The procedure was in-serviced to current nursing staff on 12/9/14.</li> </ul> </li> </ul>		

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F 281	<p>Continued From page 4</p> <p>documents, "An incident is any event not consistent with the routine operations of a health care unit or routine care of the patient. Examples included...medications errors...Reporting of incidents helps in the identification of high-risk trends in nursing care or daily unit operation that warrant correction...The reports are an important part of a units quality improvement program...Use critical thinking skills to systematically and carefully determine what was involved in the incident... Record the exact sequence of the events involved in the incident...and observation of factors that may have contributed to the incident...Document on incident report form as quickly as possible. The closer to the event, the more accurate the recording"</p> <p>Review of the facility's medication incident reports for January 1, 2014 through November 14, 2014, revealed 9 medication errors, one of which was a significant error. The facility failed to analyze the cause of the medication errors and take appropriate action to prevent reoccurrence for 6 of the 9 medication errors as follows:</p> <p>1. Transcription Errors</p> <p>a) On 1/8/14 a Medication Error Analysis Tool (MEAT) was completed by the DON for Resident #11. The report documented that on 1/2/14 (6 days earlier) the resident's order for morphine sulfate was, "entered incorrectly as PRN not scheduled." The report documented the RHIT transcribed the order incorrectly. The MEAT did not include the actual order or the form or dosage of the medication. It documented the resident's reaction to not receiving the scheduled morphine as, "Taking more Oxycontin." The Medication Error Classification section was not completed. In</p>	F 281	<ul style="list-style-type: none"> <li>o Resident's 6, 9, 10, 11, and 12 charts were reviewed for medication orders accuracy for each resident involved to confirm type of medication, administration time, and route of medication dispersal to each resident.</li> <li>• How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective actions(s) will be taken             <ul style="list-style-type: none"> <li>o Medication Administration Records of current residents have been reviewed for accuracy.</li> <li>o All residents who are prescribed medications or treatments will be reviewed at the time of admission by the DNS.</li> <li>o A 72 hour chart check will then review all new residents for medication accuracy.</li> <li>o Residents with medication changes will be reviewed by the DNS for accuracy and administering routes of medications. Any errors will</li> </ul> </li> </ul>	

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F 281	<p>Continued From page 5</p> <p>addition, there was no documentation addressing how the transcription error was discovered, why it was not discovered for 6 days, how the error occurred, and what staff education or other corrective action was taken to prevent future errors.</p> <p>The resident's Physician's orders documented a 1/2/14 order for Morphine Sulfate ER 15 mg PO TID (orally 3 times per day). The January 2014 MAR documented the resident only received 1 dose of the morphine sulfate on 1/3, 1/4, 1/6, and 1/7 and 2 doses on 1/5/14. This order was discontinued on 1/8/14 when the physician ordered Morphine Sulfate 15 mg by mouth every 8 hours. The medication was administered as ordered, per the MAR.</p> <p>b) On 1/3/14 a 2nd transcription error, by the same RHIT, resulted in Resident #10 not receiving 2 of 4 doses of an ordered antibiotic. The resident was sent to the hospital for intravenous antibiotic (Refer to F333 for details). The MEAT was not initiated for this error until 1/6/14, 3 days after the error occurred.</p> <p>c) A 3rd transcription error, by the same RHIT, was documented on 1/28/14. The MEAT documented Resident #6 received Atropine Sulfate 1% in her eyes rather than under her tongue as indicated on the prescription sent to the facility by the pharmacy. The error was described as, "Atropine drops instilled in [resident's] eyes according to hospice nurse and DON." A handwritten statement documented, "Orders clearly state under her tongue which is usual and customary for hospice patients." However, the attachments included in the MEAT indicated the route or mode of administration was</p>	F 281	<p>be amended and reported to the physician, resident, family, and Administrator immediately.</p> <ul style="list-style-type: none"> <li>• What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur <ul style="list-style-type: none"> <li>o Corrective action was administered to the employee as well as individual education performed by the Administrator with the DNS regarding the use of a Root Cause Analysis and Action Plan for prevention of medication errors which must be used by the DNS each time a medication error occurs.</li> <li>o Reports will be analyzed for accuracy and appropriate interventions implemented with each medication error.</li> <li>o In-service to nursing staff was performed by the consulting pharmacist (pharm D) and the Director of Pharmacy regarding the prevention of medication errors on 12/15/14.</li> </ul> </li> </ul>		

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F 157	Continued From page 3 legs she indicated yes..."	F 157	<ul style="list-style-type: none"> <li>Indicate how the facility plans to monitor performance to ensure the corrective actions(s) are effective and compliance is sustained                             <ul style="list-style-type: none"> <li>The Administrator, DNS, management team will monitor and review all Unusual Occurrence Reports per "Accidents, Incidents and Unusual Occurrence Recording and Reporting" policy. The monitoring includes ensuring that reports are accurate and reported properly and a full investigation is initiated, and appropriate interventions are put into place with each incident.</li> <li>Audits of completed incident reports will be conducted by the Administrator, DNS and Management team reviewed at the monthly QA Committee meeting. X 6 months and ongoing.</li> </ul> </li> </ul> <p><b>F-281 Services Provided Meet Professional Standards</b></p> <ul style="list-style-type: none"> <li>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice</li> </ul>	
F 281 SS=E	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure standards of practice were observed related to passing medication, preventing medication errors, and analyzing medication errors to prevent reoccurrence. This was true for 5 of 9 residents reviewed for medication errors (#s 6, 9, 10, 11, &amp; 12). The lack of a thorough investigation to ensure medications were administered as ordered, with the correct dose, by the proper route, and without significant error placed these and other residents in the facility at risk for compromised health status. Findings included:</p> <p>U.S. Food and Drug Administration's Division of Medication Error Prevention defines a medication error as, "... any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional..."</p> <p>The 7th Edition of Perry &amp; Potter's Clinical Nursing Skills and Techniques, page 61,</p>	F 281		<p>12/23/14</p> <p><i>See action item of 11/26/2015 for further info. ASR/Phy/DR</i></p>

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

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NAME OF PROVIDER OR SUPPLIER  BELL MOUNTAIN VILLAGE & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 706 SOUTH MAIN STREET HAILEY, ID 83333	
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F 281	<p>Continued From page 6</p> <p>not clearly indicated on the physician's orders or in the transcription of the medication as follows:</p> <p>* A photo copy of the box which contained the Atropine 1% listed the order as, "Place two [drops] under the tongue every 4 hours as needed for secretions."</p> <p>* A photo copy of the 1/24/14 physician's order documented, "Atropine 1% oph[almic] solution 2 drops every 4 hrs PRN." The order did not state the route of administration (i.e. in the eyes or sublingual).</p> <p>* A photo copy of the 1/23/14 order as it was entered into the computer to be transcribed to the MAR documented, "Atropine % ophthalmic solution 2 drops every 4 hours prn." The mode or route of administration was not indicated.</p> <p>There was no documentation that the order was clarified or that explained the three photocopies attached to the report. The MEAT documented RN #1 was involved but did not address the rest of the system breakdown, what other staff were involved, and/or all corrective actions taken.</p> <p>2. Administration Errors (Wrong medication and/or Wrong Dose)</p> <p>a) A MEAT, dated 1/26/14, documented RN #6 administered 4 mg of Clonazepam to Resident #11 instead of the 2 mg ordered by the physician. The MEAT, signed by the DON on 1/27/14, did not indicate the classification of the error, if any harm was done to the resident, how the error occurred or any corrective action taken.</p> <p>b) A MEAT, dated 1/27/14, documented LN #6 failed to administer Resident #12 a 0.5 mg dose of Clonazepam on 1/24/14. The MEAT, signed by the DON on 1/27/14, did not indicate the</p>	F 281	<ul style="list-style-type: none"> <li>o Nurses and RHIT were in-serviced on 12/15/14 "Physician Order Processing Procedure" to ensure all steps are completed on every new order. The 24-hour process also reviewed.</li> <li>o Data from the Root Cause Analysis, Medication Error Analysis Tool, and the Action Plan will be evaluated and revised, as necessary, to ensure this does not occur again.</li> <li>• Indicate how the facility plans to monitor performance to ensure the corrective actions(s) are effective and compliance is sustained             <ul style="list-style-type: none"> <li>o All new physician orders will be processed per the "Physician Order Processing Procedure" and monitored by the DNS and RHIT for accuracy.</li> <li>o All new orders will be processed using the 24hr check procedure by the night nurse daily.</li> <li>o The DNS will monitor all new orders for accuracy weekly x 4, every 2 weeks x 2 and monthly x 3.</li> </ul> </li> </ul>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C - 11/19/2014
NAME OF PROVIDER OR SUPPLIER  BELL MOUNTAIN VILLAGE & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 706 SOUTH MAIN STREET HAILEY, ID 83333		
(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 281	Continued From page 7 classification of the error, if any harm was done to the resident, how the error occurred or any corrective action taken.  c) A MEAT, dated 3/5/14, documented LN #7 administered Resident #9 750 mg of Zithromycin instead of the Levaquin 750 mg ordered by the resident's physician. The MEAT, signed by the DON on 3/6/14, did not document the classification of the error, if any harm was done to the resident, how the error occurred and was discovered, or any corrective action taken.  During an interview on 11/13/14 at 12:55 pm, the DON and AIT were asked to provide any additional documentation indicating the above incidents had been investigated and corrective action put into place. The DON provided copies of staff counseling forms for RN #1, who was involved in 4 of the errors in January 2014. The DON indicated RN #1 was not the only staff involved in the errors but he was the only one for whom she could show consistent corrective action. The DON was only able to provide investigations with analysis of the errors and corrective action taken for 3 of the 9 errors that occurred.  On 11/19/14 at 3:00 pm, the Administrator, DON and AIT were informed of the medication error investigation concerns. The facility provided additional information on 11/20/14 which did not alleviate the concerns.	F 281	<ul style="list-style-type: none"> <li>o The QA committee will review the process and continue to strive for zero medication errors.</li> </ul> Start date of the audit: 12/16/14  End date of the audit: 5/10/15		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain	F 309			

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F 309	<p>Continued From page 8 or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure LNs assessed and monitored residents when they were notified of resident health concerns by CNA staff. This was true for 1 of 3 residents (#6) reviewed for medical/health conditions. Failure to assess the resident in a timely manner put the resident at risk for an unnoticed decline in medical condition. Findings included:</p> <p>Resident #6 was a long term resident of the facility since 2007. The resident's last re-admission date was 1/7/14. The resident's diagnoses included senile dementia, vascular dementia, malnutrition, hypertension, coronary artery anomaly, and atrial fibrillation.</p> <p>Resident #6's most recent Quarterly MDS assessment, dated 11/13/14, coded long and short term memory problems, severe cognitive impairment - never/rarely made decisions, disorganized thinking and total assistance of 1 - 2 people for all ADLs.</p> <p>Physician's orders, dated 1/7/14, instructed staff to administer the following medications for hypertension: * Amlodipine besylate 5 mg tablet 1 by mouth Q HS (every bedtime). Administer if SBP (systolic -the upper number- blood pressure) is greater.</p>	F 309	<p><b>F-309 Provide Care/Services for Highest Wellbeing</b></p> <ul style="list-style-type: none"> <li>• What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice <ul style="list-style-type: none"> <li>○ Resident #6 chart was reviewed. The attending Physician discharged the Resident to the hospital for other medical issues affecting her health on 1/17/14. Resident 6 was then readmitted back to the care center on 1/18/14 on Hospice Services for palliative care. All Medication orders and Advanced Directives were followed as per Hospice MD orders. Resident 6 passed away on 1/30/14 incident to significant medical issues.</li> </ul> </li> <li>• How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective actions(s) will be taken <ul style="list-style-type: none"> <li>○ All resident's charts were reviewed on 1/18/14 to insure Vital signs and Medication</li> </ul> </li> </ul>	12/23/14	

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F 309	<p>Continued From page 9 than 160.</p> <ul style="list-style-type: none"> <li>* Lisinopril 40 mg tablet 1 by mouth every day</li> <li>* Catapres 0.1.mg tablet 1 by mouth two times per day. Hold if SBP is less than 120.</li> </ul> <p>The resident's care plan, updated on 1/22/14, listed a Problem/Need of hypertension related to coronary artery anomaly. Interventions included:</p> <ul style="list-style-type: none"> <li>* Give medications per physician's order</li> <li>* Record weekly and prn vital signs on graphic sheet in chart</li> <li>* Report any changes to physician</li> </ul> <p>A Daily Vital, Weights, O2 Sats (oxygen saturation) form and a corresponding Vital Signs Roster form, dated 1/16/14, documented:</p> <ul style="list-style-type: none"> <li>* Resident #6's BP was recorded at 90/62 with a pulse of 57, during morning vital signs taken by CNAs. The form documented the resident's BP was rechecked at some unknown time on the same morning and was recorded as 125/96.</li> <li>* Another set of vital signs was recorded at 3:21 PM. The BP was 94/57. No recheck was documented.</li> <li>* On 1/16/14, no time noted, the PM shift recorded the resident's BP as 198/115 and pulse 147. There was no documentation on these sheets that the resident's BP was rechecked or the Amlodipine was administered for a SBP greater than 160, as ordered.</li> </ul> <p>Nurses Notes (NNs) were reviewed for 1/15/14 - 1/20/14. The NNs did not address the resident's BP or any actions taken on 1/16/14 &amp; 1/17/14, until 1/20/14 at 4:15 pm. At that time a late entry was made by the charge nurse who was on the night shift on 1/16/14. The charge nurse (LN #1) documented, "Late entry from 1/17/14 NOC [night] shift. RN to recheck BP. Resident seemed</p>	F 309	<p>regimens were followed and communication was documented per Nursing Policy and Procedure to ensure this would not occur again.</p> <ul style="list-style-type: none"> <li>o The licensed nurse involved was terminated last spring due to failure to follow progressive coaching.</li> <li>o In-service regarding Nurse/CNA communication 12/9/14 included: Vital Signs form, "Hypertension" policy, CNA Scope of Practice, CNA/Nurse Communication Sheet, Chain of Command</li> </ul> <ul style="list-style-type: none"> <li>• What measures will be put in place and/or what systemic changes will be made to ensure that deficient practice does not recur. <ul style="list-style-type: none"> <li>o CNA/Nurse Communication sheet to be used daily and reviewed at each stand up meeting to ensure that all information regarding residents needs are communicated to all staff.</li> <li>o The CNA Daily Vitals form was revised to include dates, times and signatures. The forms will</li> </ul> </li> </ul>		

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F 309	<p>Continued From page 10</p> <p>to be sleeping/resting well [at] that time. [Note: the time of the recheck was not documented] Staff to alert RN that resident does not look ok [No time documented]. Resident diaphoretic, BP 164/89, HR 164, Temp 99.4, O2 75% on 2 L NC [Nasal Cannula], RR [Respiratory Rate] 50. RN to administer 6 L via mask, sats [at] 90%. RN to call [resident's physician]. New orders received [to] transport resident to hospital.... Resident to be transported around 3:00 am."</p> <p>A 1/23/14 NN documented the resident was re-admitted via non emergent transport. She was returned to the facility on comfort measures and hospice services with a diagnosis of pneumonia. Her orders included IV (intravenous) antibiotics, continuous flow of IV fluids, and 6 L continuous flow of oxygen per mask. Per NNs, the resident expired on 1/30/14.</p> <p>On 11/13/14 at 5:25 am, CNA #2 was asked if she was familiar with the incident with Resident #8 on 1/16/14 PM shift. The CNA stated she was and the resident's BP was taken between 4 and 5 pm on 1/16/14. The CNAs notified the charge nurse (LN #8) that the resident's BP and pulse were high. The charge nurses stated she thought it was an error. The BP was not rechecked. The CNA reported the BP reading and pulse to the shift arriving at 7:00 pm. CNA #2 stated she was not sure when they checked the resident or took vital signs. CNA #2 stated there had been many incidences (she named 2 others which could not be co-oberated due to lack of documentation), but LN #8 and another LN (#9), who often ignored reports from the CNAs, no longer worked at the facility. She stated the current LNs are much better at responding to CNA reports and concerns.</p>	F 309	<ul style="list-style-type: none"> <li>be reviewed for accuracy in performing Vital Statistics and completing the forms as required by the DNS, and charge nurses. Any deviance from the form will be addressed by the HR Director, DNS and Administrator.</li> <li>Indicate how the facility plans to monitor performance to ensure the corrective actions(s) are effective and compliance is sustained             <ul style="list-style-type: none"> <li>The DNS will monitor the Daily Vital Signs flow-sheet and CNA/Nurse Communication sheet daily x 2 weeks, weekly x 4, monthly x 3 starting 12/16/14</li> </ul> </li> <li>Start date of the audit: 12/16/14</li> <li>End date of the audit: 4/28/15</li> </ul>		

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F 309	Continued From page 11  The AIT and DON were interviewed on 11/14/14 at 10:30 AM. The AIT confirmed that the first evening vital signs are generally taken around 5:00 PM. The DON stated they were aware of issues with LNs not following up with resident concerns brought to them by the CNAs, as well as the problems with LNs not documenting events that occurred on their shift. The DON stated both of the nurses listed above have been terminated from the facility. She also stated that change in conditions are now written on the 24 hour report and discussed in the daily (Monday - Friday) Stand-up Meeting. Actions taken and documentation are now reviewed by the DON, AIT or designated individual on a daily basis.  On 11/19/14 at 3:00 pm the DON, AIT, and administrator were informed of the deficient practice. No additional information was provided that resolved the concern.	F 309			
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  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.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to provide adequate supervision and care planning	F 323	F-323 Free of Accident Hazards/Supervision/Devices  • What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice o Residents 1, 5, 7 and 9, Plans of Care were reviewed and updated taking into consideration the resident's individual needs related to fall and elopement risks.	12/23/14	

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F 323	<p>Continued From page 12</p> <p>needed to prevent resident falls and wandering. This was true for 4 of 8 residents reviewed (#s 1, 5, 7, &amp; 9) for falls and wandering.</p> <p>* Resident #5 was harmed when she fell and fractured her pelvis and required hospitalization. The resident continued to fall after returning to the facility.</p> <p>* Resident #1 was put at risk for hypothermia and injury when she exited the facility and was later found lying face down in the snow.</p> <p>* Resident #7 was placed at risk for harm when she fell and injured her leg while attempting to move away from a resident who was wandering and disturbing residents in the facility.</p> <p>* Resident #8 had the potential to harm himself and put other resident at risk for psychosocial harm when he wandered into other residents' rooms and individual space.</p> <p>Findings include:</p> <p>1. Resident #5 was initially admitted to the facility on 12/20/13 and readmitted to the facility on 2/4/14 after a hospitalization for a fall which resulted in a fractured pelvis. The resident's initial diagnoses included alcohol dependence, chronic lymphocytic leukemia, malaise and fatigue, failure to thrive, and lumbar spinal stenosis.</p> <p>Resident #5's 12/27/13 admission MDS assessment coded a BIMS of 9 indicating a moderately affected cognitive status; resistance to cares; extensive assistance of at least one person needed with bed mobility, transfers, dressing, and toilet hygiene; able to walk in room with the moderate assist of one person, walker or wheelchair for mobility; not able to steady self without human assistance when ambulating or transferring; and, almost constant severe pain.</p>	F 323	<ul style="list-style-type: none"> <li>• How will you identify other residents how have the potential to be affected by the same deficient practice and what corrective actions(s) will be taken             <ul style="list-style-type: none"> <li>o All care plans of current residents have been reviewed and updated for appropriate safety measures use.</li> <li>o All new admissions will be assessed for fall risk and elopement risk and those risks will be included in plan of care with individualized interventions.</li> <li>o Plan of Care will be reviewed and updated at a minimum of quarterly, with change of condition, and at other times to meet resident's individual needs.</li> </ul> </li> <li>• What measures will be put in place and/or what systemic changes will be made to ensure that deficient practice does not recur             <ul style="list-style-type: none"> <li>o 12/3/14 QA/PI Committee met and approved the implementation of a new root cause analysis tool to</li> </ul> </li> </ul>		

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F 323	<p>Continued From page 13</p> <p>Physician's admission orders, dated 12/20/13, included: * Hydrocodone-Acetaminophen 10-325 1 PO (by mouth) every 4 hours PRN; * May have ETOH [alcohol] with meals and PRN. This order was changed on 1/10/14 to read, "Offer resident ETOH-free wine. Resident may have two glasses.</p> <p>The Resident's Nursing Intervention/Initial Care Plan, dated 12/20/13, listed: Physical Function and Structural Problems: * "Encourage use of call light" * "Night light on [at night]" * "Keep path clear in room" * "Keep items within reach" * "Appropriate footwear"</p> <p>Nurses Notes (NN), dated 12/20/14 through 1/2/14, documented the resident used Norco 10-325 at least one time per day, frequently at bedtime and often drank one to two glasses of wine with the evening meal.</p> <p>Resident Incident and Accident Reports (I&amp;As) and NNs, dated 1/1/14 through 2/2/14, documented the resident experienced 2 non-injury falls in 1/2014 and a fall with pelvic fractures and hospitalization on 2/2/14.</p> <p>Falls on 1/1/14 * A 2:30 am NN, documented, "... [resident] was up independently as usual to the bathroom. She was standing at the sink washing her hands and apparently lost her balance and fell behind the bathroom door."</p> <p>The corresponding I&amp;A, dated 1/1/14</p>	F 323	<p>be used as part of the Falls Prevention policy.</p> <ul style="list-style-type: none"> <li>o Emphasis will be placed on prevention of falls using appropriate interventions based on the individual's risk factors.</li> <li>o New interventions will be implemented after each fall in an effort to prevent future falls.</li> <li>o Reviewed and updated Electronic Medical Record (EMR) to reflect current resident behaviors and risk factors related to falls and elopement.</li> </ul> <ul style="list-style-type: none"> <li>• Indicate how the facility plans to monitor performance to ensure the corrective actions(s) are effective and compliance is sustained <ul style="list-style-type: none"> <li>o Beginning 12/16/14 the AIT and DNS will monitor the data using the root cause analysis tool weekly x 12.</li> <li>o Beginning 12/16/14 the DNS will monitor the CNA Electronic Medical Record and will monitor documentation for fall and elopement prevention daily</li> </ul> </li> </ul>	

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F 323	<p>Continued From page 14</p> <p>documented the fall was not witnessed, the resident walked to the bathroom on her own, there was no apparent injury from the fall, and the resident was encouraged to use her call light when ambulating in the room. The I&amp;A did not address when the resident was last assisted to toilet or visualized or why she did not use the call light and wait for assistance or how she fell.</p> <p>The Immediate Post-Incident Action Plan documented, "increase frequency of status checks while resident is in her room."</p> <p>A 1/1/14 NN at 7:10 AM documented the resident "... got up to bathroom again unattended after it was requested that she call for standby assistance. Incontinent of large stool everywhere... Door left open for closer monitoring..."</p> <p>A 1/1/14 NN at 3:30 PM documented, "Bed alarm placed on bed for resident's protection..."</p> <p>Between 1/1/14 and 1/21/14 the following observations were documented in the resident's NNS:</p> <p>* 1/2/14, 3:43 am, "She does not use her call light to ask for assistance when she gets up and has been steady and unsteady on her feet..."</p> <p>* 1/3/14 at 3:57 am, "A regular night light is found to replace the regular overbed light... will continue to monitor as closely as possible since she is unsteady on her feet at times..."</p> <p>* 1/6/14 at 3:50 am, "[Alert and oriented x 3], confused [at] times about where some of her things are, able to make needs known. Resident</p>	F 323	<p>x 2 weeks, weekly x 4, 2 weeks x 4, monthly x 3.</p> <ul style="list-style-type: none"> <li>o Monthly, fall risk residents will be reviewed by the QA to ensure the highest practicable, accident free lifestyle, will be attained.</li> <li>• (Note date error on page 14/31 "Nurses Notes (NN), dated 12/20/14..." should be 12/20/13).</li> </ul> <p>Start date of the audit: 12/16/14</p> <p>End date of the audit: 6/24/15</p>		

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NAME OF PROVIDER OR SUPPLIER  BELL MOUNTAIN VILLAGE & CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 706 SOUTH MAIN STREET HAILEY, ID 83333		
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F 323	<p>Continued From page 15 with short term memory loss... "</p> <p>There was only one NN between 1/1/14 and 1/10/14 that documented staff increased monitoring to every hour. There was no documentation of hourly room checks between 1/1/14 and 1/22/14.</p> <p>Fall on 1/21/14 * 1/21/14 at 8:41 am, a NN documented, "Resident found on floor... stating she was going to the bathroom when she fell... Resident was quite stubborn, not using call light and trying to refuse help getting up."</p> <p>The corresponding I&amp;A, dated 1/22/14, documented, "Resident fell while trying to go to the bathroom alone, was barefoot, call light within reach and the facility provided, ... staff in-service training regarding proper foot wear while using walker and resident teaching regarding use of her call light." The Immediate Post-Incident Action documented, "Frequent reminder to use call light, and ask for assist prior to getting OOB [Out of Bed], and keep night light on at all times."</p> <p>The I&amp;A did not document an analysis of why the resident continued to get out of bed without asking for assistance, analysis of voiding issues (i.e. urgency, leakage, stress incontinence), if interventions such as a voiding schedule would be helpful, if medications and/or wine intake may be involved, why the "increased monitoring" that was implemented on 1/1/14, was not working or if hourly monitoring was actually occurring. In addition, there was no analysis as to whether the resident's moderate cognitive impairment was interfering with her understanding and/or remembering staff instructions to use the call light</p>	F 323		

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F 323	<p>Continued From page 16 before getting out of bed.</p> <p>Fall with fracture on 2/2/14 * NNs dated, 2/2/14 at 1:20 am, documented staff "... heard a crash and resident was yelling out. Resident was found on the floor in a puddle of urine, complained of pain, was sent to the emergency room where she was hospitalized with a fractured pelvis."</p> <p>The corresponding I&amp;A, dated 2/2/14, documented, "The resident may need to have a mat alarm to alert staff [that] resident may need assistance... Resident's CP [care plan] will be updated when returns from hospital." NNs, Care Plans, &amp; I&amp;As did not document whether the mat alarm was placed after the resident returned to the facility.</p> <p>The 2/2/14 I&amp;A documented, "The resident has demonstrated she knows how the call light [works]. Resident has refused assistance to the bathroom in the past..." However, the I&amp;A failed to provide an indepth analysis of why the resident was refusing assistance, to what degree her cognitive status limited her full understanding of using the call light to go to the bathroom, how her medications and continued wine intake could be affecting why she was falling and/or refusing to call for assistance. In addition, the I&amp;A did not address if hourly checks were still being completed and if hourly checks were/were not effective.</p> <p>Resident #5 returned to the facility on 2/4/14 with a discharge diagnosis of "Acute fall at nursing home with pelvic fracture and pelvic hematoma, Anemia, secondary to acute fall at nursing home with pelvic fracture, chronic pain syndrome, with</p>	F 323			

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F 323	<p>Continued From page 17</p> <p>chronic narcotic use." The resident was on bedrest when she returned from the hospital and had an Indwelling catheter, which was discontinued prior to 2/14/14. No documentation was found that specified when the catheter was discontinued.</p> <p>Following her return from the hospital, the resident experienced 6 more documented falls between 2/14/14 and 6/9/14:</p> <p>One of these falls (2/14/14) occurred within 10 days of the resident's return to the facility. An I&amp;A, dated 2/14/14, documented the resident was found on the floor next to bed. The tab alarm was not on the resident.</p> <p>The 2/14/14 I&amp;A and associated care plan documented a sensor alarm was placed at the resident's bedside to alert staff when the resident placed her legs over the bed rails. The resident refused the alarm stating, "I do not need them and will not have them." No root cause analysis was documented on the event, nor was any new interventions implemented, other than the sensor alarm which the resident was refusing:</p> <p>Resident #5 experienced additional falls on 3/5/14, 4/17/14, 5/16/14, 5/19, and 6/9/14. No root cause analyses of the falls were found. Interventions included the following: 3/5/14 - Nurse completed a verbal Safety Contract with the resident, increased frequency of checks to every 15 minutes (no documentation of checks were provided). The I&amp;A documented a bedside commode "which had been positioned next to the bed was immediately outside the bathroom door." 4/17/14 - Motion sensor alarm, group in-service</p>	F 323		

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F 323	<p>Continued From page 18</p> <p>regarding alarms being turned on; . 5/16/14 - Commode next to bed (Based on I&amp;A this had already been in implemented. See documentation on 3/5/14 incident report.). The resident developed a large goose egg/bruising on her forehead, complained of increased pain in back; 5/19/14 - Implemented constant supervision of resident while up in wheelchair (Neither NNS or monitoring sheets documented this level of supervision); and, 6/9/14 - Airbed overlay removed due to being slippery.</p> <p>After each fall listed above, the facility stated one of the interventions would be to re-educate the resident regarding the use of the call light and, on 3/5/14, develop a safety contract with the resident. However, the resident's Quarterly MDS Assessment, dated 3/26/14, documented a BIMS of 2 (it was 8 when the resident was admitted) indicating the resident had gone from a moderate cognitive deficit to a severe cognitive impairment, which affected her memory and ability to recall.</p> <p>On 11/13/14 at 11:25 AM, the DON and AIT were interviewed regarding Resident #5's falls, lack of documentation of root cause analyses of the falls, and documentation of decisions made regarding preventative interventions, based on the analysis of the cause of the falls, that were put into place to prevent further falls and injuries: * 1/1/14 fall- the DON stated the cause of the fall was that the resident lost her balance while washing her hands. There was no investigation into why she lost her balance or any other contributing factors. Although the resident was re-educated to use the call light when needing to get out of bed, the DON stated the resident</p>	F 323		

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F 323	<p>Continued From page 19</p> <p>continued to go to the bathroom unattended and a motion sensor bed alarm was put into place, and a night light was at the resident's bed.</p> <p>*1/21/14 fall - the DON said the resident was again reminded to use the call light and ask for assistance to get out of bed. Staff was instructed to frequently ask the resident if she needed to go to the bathroom, remind her to keep her call light within reach, and ensure she was wearing proper foot wear. The DON was not able to confirm that the root cause of the falls and contributing factors were formally discussed and documented.</p> <p>Because both the 1/5/14 fall and the 1/21/14 fall involved the resident going to the bathroom without assistance, the DON was asked if the facility had considered a toileting schedule based on her voiding assessment. The DON indicated this had not been discussed. When asked if her use of wine and Norco between dinner and bedtime had been evaluated in relationship to her falls, the DON indicated neither factor had been considered.</p> <p>The DON was asked to provide documentation (i.e. NNs or monitoring check sheets) of frequent monitoring and checks of the resident. However, none were provided for January 2014.</p> <p>On 11/14/14 at 2:00 pm, the DON and AIT were informed that the resident had experienced harm when she fell at the facility on 2/2/14 and fractured her pelvis, requiring hospitalization. The resident experienced two falls in the month previous to this. The facility failed to analyze the root cause of the falls and determine/put into place interventions based on the root cause of the falls. In addition, the interventions put into place, such as re-educating the resident, who</p>	F 323		

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F 323	<p>Continued From page 20</p> <p>was cognitively impaired, were not effective in preventing the resident from falling and injuring herself.</p> <p>2. Resident #7 was admitted to the facility on 2/14/14 with diagnoses of depressive disorder, post fracture right hip, congestive heart failure and cerebral vascular accident.</p> <p>The most recent Quarterly MDS, dated 8/20/14, documented the resident had short and long term memory problems; had moderately impaired decision making skills; required extensive assistance of one staff for transfers, dressing, and personal hygiene; and impaired range of motion on one side.</p> <p>The resident's care plan for falls, dated 2/14/14, identified numerous interventions including:</p> <ul style="list-style-type: none"> <li>* Ensure the resident has and wears proper-fitting non-skid soled shoes for ambulation;</li> <li>* Assess resident's need for assistive/supportive device;</li> <li>* Instruct resident on appropriate use of assistive/supportive device, and</li> <li>* Maintain resident environment free of clutter and safety hazards.</li> </ul> <p>Based on review of an 11/1/14 I&amp;A and Occurrence Report (OR) and an Investigative Report (IR) submitted to BFS on 11/7/14, the following occurred:</p> <p>The IR documented on 11/1/14 at about 7:30 PM, Resident #7 was taken to her room after dinner. The CNA left the room and closed the door. The IR further documented, the "door was closed to help prevent possible intrusion by a resident, [the other resident's name] during a particularly</p>	F 323		

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F 323	<p>Continued From page 21</p> <p>agitated state." The OR documented the other resident had already physically attacked a staff member. The DON had to provide 1:1 assistance to the other identified resident who was engaged in aggressive behavior.</p> <p>The I&amp;A documented on 11/1/14 at 8:30 PM Resident #7, "was laying [sic] on the floor in front of her wheelchair with her left leg caught in an awkward position." The resident was transported to the hospital at 9:00 PM.</p> <p>The hospital emergency report documented the resident did not have a fracture; however, the resident did have a skin tear that was treated and returned to the facility. The resident returned to the facility at 11:00 PM with a dressing over the leg injury.</p> <p>The DON and AIT were interviewed on 11/14/14 at 11:45 AM. They stated the resident was not unattended for more then a couple minutes. However, all the documentation indicated the resident was unattended for up to one hour. The staff were busy with an aggressive resident, and the documentation was vague with what facility staff was doing from 7:30 PM to 8:30 PM; when the Resident #7, who was unattended and had her room door closed, was found on the floor in her room.</p> <p>3. Resident #8 was admitted to the facility 9/21/14 with diagnoses of dementia with behavior disturbance and Alzheimer's disease.</p> <p>The Admission MDS, dated 10/4/14, documented the resident had short and long term memory problems; had severely impaired decision making skills; wandered daily; was at significant risk for</p>	F 323		

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F 323	<p>Continued From page 22</p> <p>getting to a potentially dangerous place; and, wandered significantly intruding on the privacy and activities of others.</p> <p>The 9/21/14 care plan included no plan for the resident's intrusive wandering.</p> <p>The facility's "CNA Guide" for the resident was reviewed. Under the heading of "Behavior/Mental", "Goes into other resident's rooms" was listed. Also "Wanders" and "Elopement Risk" were checked. No interventions were documents related to these behaviors.</p> <p>On 11/12/14 at 4:30 PM the resident was observed to wander into room 38. The resident who lived in that room was in her wheelchair with her back to the door. The resident walked to within 2 feet of the resident in room 38, stood for about 30 seconds and left the room. No staff were in the area.</p> <p>On 11/13/14 at 1:30 PM Resident #8 wandered into room 32. The resident in that room was eating her lunch when Resident #8 entered the room. A CNA entered and escorted the resident out of the room. The CNA asked Resident #8 what he wanted. He indicated he was looking for a bed. The CNA took him to his room so he could lie down.</p> <p>The DON and AIT were informed of the issue on 11/14/14 at 11:45 AM. The facility did not have a policy on dealing with the types of behavior that Resident #8 exhibited and there was no evidence of a supervision plan for Resident #8 who wandered intrusively throughout the facility. No further information was provided.</p>	F 323		

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F 323	Continued From page 23 4. Resident #1 was admitted to the facility on 6/6/12 with diagnoses of dementia, malaise and fatigue, kyphosis, spinal stenosis and depressive disorder.  The most recent Quarterly MDS, dated 8/14/14, documented the resident had severely impaired cognition with a BIMS of 4; and, required extensive assistance of one to two staff for transfers, dressing; eating, personal hygiene and bathing.  An I/A dated 1/26/14 at 6:30 PM documented the resident was found outside the facility's front door, at the end of the ramp, on her knees in the snow. The report documented the resident was observed at dinner at 6:00 PM. The resident left the dining room independently in her wheelchair. Around 6:30 PM, the RN heard someone yelling "help." The RN and a CNA went looking for who was yelling. They found the resident outside the facility kneeling in the snow after falling out of the wheelchair.  The facility failed to supervise the resident who was able to exit the building and ultimately fall out of her wheelchair into the snow. The DON and AIT were informed 11/14/14 at 11:45 AM. No further information was provided.	F 323			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329	F-329 Drug Regimen is Free from Unnecessary Drugs  • What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice	12/23/14	

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F 329	<p>Continued From page 24</p> <p>adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure a resident who was receiving psychotropic medications had an effective plan in place to address maladaptive behaviors and ensure adequate monitoring. This was true for 1 of 8 (# 4) sampled residents. Failure to ensure the implementation of effective behavioral interventions, including for intrusive wandering, and effective monitoring placed this resident and other residents in the facility at risk for injury. Findings include:</p> <p>Resident #4 was admitted to the facility, on 10/27/14, with diagnoses of frontal temporal dementia, insomnia due to mental disorder, psychosis and Alzheimer's disease.</p>	F 329	<ul style="list-style-type: none"> <li>o Resident #4 was discharged on 11/15/14, although his medical chart and care plan were reviewed for analysis of psychotropic medication use and non-pharmalogical behavioral interventions on care plan and what further steps could have been used to increase staff awareness and lessen negative behavioral outbursts that were problematic for other Residents and staff.</li> <li>o All affected Residents were interviewed and observed for any signs of emotional trauma as a result of Resident #4, none were affected and all were happy</li> <li>Resident #4 had been discharged;</li> <li>▪ How will you identify how other residents how have the potential to be affected by the same deficient practice and what corrective actions(s) will be taken             <ul style="list-style-type: none"> <li>o All residents who have been prescribed a psychotropic medication have the same potential to be affected.</li> </ul> </li> </ul>		

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F 329	<p>Continued From page 25</p> <p>The 11/7/14 Admission MDS documented the resident had moderately impaired decision making skills; exhibited constant disorganized thinking; had behaviors of physical aggression, verbal aggression and other types of inappropriate behaviors 1 to 3 days a week; the behaviors impacted other residents, intruded on the privacy or activity of others, and significantly disrupted care in the living environment; and wandered dally which impacted other residents privacy, interrupted activities and put the resident at risk for potential danger.</p> <p>Physician admission orders documented the resident was to receive Seroquel 100 mg tablet orally every day at 6:00 PM. On 10/30/14 at 2:00 PM the resident was seen by the physician who ordered Ativan .5 to 1 mg orally every 8 hours PRN for anxiety.</p> <p>The facility's care plan did not address the use of psychoactive medications and/or include interventions for maladaptive behaviors identified on the MDS.</p> <p>The undated "[Facility name] CNA Guide" documented the resident had behaviors of, "Agitated/Anxious, Aggressive, Physical, Wanders, Intrusive, and Elopement risk." No behavioral interventions were identified.</p> <p>A behavior care plan, dated 10/27/14, from the psychiatric facility the resident was in prior to admission to the facility, included the following: "1. Redirect [Name] away from the inappropriate behavior. 2. Remain calm and offer an assertive reminder of appropriate behavior. 3 Redirect [Name] by exploring with him an</p>	F 329	<p>Medical Records of residents with a psychotropic medication have been reviewed by the psychotropic committee.</p> <ul style="list-style-type: none"> <li>o Care Plans of residents who are prescribed psychotropics have been updated to include adequate monitoring, behavioral interventions and non-pharma logical interventions.</li> <li>o The Electronic Medical Record has been updated to reflect individualized EMR charting by CNA and Nurse for all residents prescribed psychotropics.</li> </ul> <p>What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur</p> <ul style="list-style-type: none"> <li>o The care plans for all residents who have been prescribed psychotropic medications will be revised quarterly and more frequently, as appropriate, to ensure that they contain behavior interventions and</li> </ul>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 26 activity of interest and helping him stay busy. 4. Provide reassurance of safety, whereabouts, and what is expected. 5. Review available coping skills and help identify which ones might be helpful in this situation. 6. If he is putting himself, others, or the property in danger, contact the administrator immediately. 7. If unable to redirect or if behavior continues to the point that it interferes with every day life, Contact [Hospital contact information]."</p> <p>The facility's Electronic Medical Record (EMR) was not set up for documenting on specific interventions or the resident's response to interventions. Resident #4's EMR revealed the CNAs documented only as follows: 10/30/14 at 10:53 AM -The resident was physical towards staff. 11/2/14 at 7:28 PM -Adverse behavior of toileting. 11/2/14 at 7:29 PM -Gestures and threatening mumbles. 11/9/14 at 2:07 PM - Spit and threw meds.</p> <p>Nursing Progress Notes revealed the resident displayed more maladaptive behaviors then were documented by the CNAs. Some examples were: a) On 10/29/14 at 5:26 PM the LN documented, "Resident became violent with staff today at approximately 1445 [2:45 p.m.]. He grabbed a CNA by the arm and it twisted up and forcing her to walk down the hall. Another CNA and RN intervened to get CNA out of resident[']s grip. RN could not get his hand open to release CNA but she was able to finally pull her thumb free. Resident then asked RN if she would like to dance. He had RN's top in his grip and had right hand in his left hand and began to 'dance' down the corridor. When resident reached another resident[']s room, he became forceful with the RN</p>	F 329	<p>non-pharma logical interventions.</p> <ul style="list-style-type: none"> <li>o The Electronic Medical Record will reflect behavior monitoring for residents who are on psychotropic meds.</li> <li>o Behavioral tracking logs have been implemented for each 24 hour day and are reviewed as needed, monthly and quarterly.</li> <li>o Nursing notes will be reviewed for those residents identified as having behavioral problems as needed, monthly, and quarterly to ensure that all direct care staff are communicating effectively to help manage problematic Residents</li> <li>• Indicate how the facility plans to monitor performance to ensure the corrective actions(s) are effective and compliance is sustained             <ul style="list-style-type: none"> <li>o The Psychotropic Committee will meet monthly. New recommendations will be presented to the primary physician. Any changes will be added or discontinued from</li> </ul> </li> </ul>	

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

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NAME OF PROVIDER OR SUPPLIER  BELL MOUNTAIN VILLAGE & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 708 SOUTH MAIN STREET HAILEY, ID 83333
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F 329	<p>Continued From page 27</p> <p>while she was trying to block him from entering other residences[sic] room. Resident grabbed the RN's right underarm and began squeezing hard. RN had to yell down the hall to a CNA for assistance. It took 3 CNA's to get resident to release RN's arm. Resident then grabbed RN's wrist, squeezing remarkably hard, and took her in the dining area....He then began grabbing silverware off the tables....Resident was able to grab a butter knife and took off out of the dining area. RN tried to get resident to give her the knife but resident would not release the knife. RN was able to slide knife out of resident[']s hand. Resident then walked down the hall, saw another CNA, held his hand up to her throat then dropped his hands. Resident was calm after that."</p> <p>b) On 11/10/14 at 6:55 PM the LN documented, "The resident was one on one from 7pm to 11pm, one on one from 3am - 7am, R/T [related to] fall risk, grabing [sic] people, going in other peoples rooms, fall risk to other resident."</p> <p>c) On 11/10/14 at 12:36 PM. the LN documented, "Resident has been one on one care this shift with a staff member at his side at all times....Is incontinent of bowel and bladder due to confusion and refusal to sit on the toilet due to cognitive issues...."</p> <p>The resident was observed by surveyors from 11/12/14 through 11/14/14. The resident had a 1:1 staff during the day and was observed with the night RN during an early morning observation on 11/14/14. The resident did not exhibit any aggressive behaviors. He wandered, but was easily redirected. The resident's wife was seen interacting with the resident. Later that day an I/A documented Resident #4 was, "noted to be</p>	F 329	<p>the care plan. The staff will be in serviced with each change and the medical record updated, as appropriate.</p> <ul style="list-style-type: none"> <li>o The DNS will review the Care Plan and other medical records as appropriate to review and update individualized non-pharmalogical interventions and behavior monitoring weekly x 4, every 2 weeks x 4, and monthly x 3.</li> <li>o The RHIT will monitor the Electronic Charting to ensure that it accurately reflects resident's current behaviors related to psychotrópic medications, non-pharmalogical interventions, and/or medical condition weekly for two weeks and then monthly and quarterly by the Care Conference committee.</li> </ul> <p>Start date of the audit: 12/16/14</p> <p>End date of the audit: 6/10/15</p>	
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F 329	Continued From page 28 pacing in TV room, appears angry, shaking head, not following verbal commands. [Name of other resident] walked into TV room, stopped at chair. Resident #4 noted to walk rapidly toward [other resident], with out-stretched arm, stopped in front of [other resident]. Resident #4 grabbed [the other resident's] shirt, garbled speech directed toward [other resident]. Resident #4 released [other resident] with shoving motion. [Other resident] walked away at this point." The resident discharged from the facility on 11/15/14.  The DON and AIT were interviewed on 11/14/14 at 11:45 AM about the resident's behaviors and the lack of a plan and/or monitoring related to his behaviors. They stated they felt facility staff dealt well with Resident #4 well but there was nothing more then the treatment plan he came with. No further information was provided.	F 329			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure LNs administered medications without potentially significant errors. This affected 1 of 9 residents reviewed for medication errors (#10). This failed practice resulted in Resident #10 being sent to the emergency room for intravenous (IV) antibiotics and had the potential to cause the resident increased health concerns if his infection were not abated. Findings include:	F 333	F-333 Resident Free of Significant Medication Errors  • What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice o Resident #10 chart was reviewed and rectified to show that he was resistant to Clpro and his new medication was in the Physician orders and administered as ordered.	12/23/14	

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F 333	<p>Continued From page 29</p> <p>Resident #10's Physician's orders, dated 1/3/14 at 8:30 am, instructed staff to administer Cipro 250 mg BID for 7 days for treatment of a urinary tract infection (UTI).</p> <p>A 1/3/14 - 1/5/14 Medication Error Analysis Tool (MEAT) documented Resident #10 missed 2 of 5 doses of the antibiotic between 1/3/14 and 1/5/14. The physician was notified of the error on the evening of 1/5/14 and the resident was transferred to the emergency room for treatment of his UTI. NOTE: Nursing Notes for that time frame documented the resident was afebrile and without acute signs/symptoms of a UTI.</p> <p>An emergency room report, dated 1/5/14, documented the resident's UTI organism was actually resistant to the Cipro, initially ordered by the resident's physician, and the resident was administered IV Rocephin.</p> <p>During an interview 11/13/14 at 7:55 AM, the DON stated Resident #10's antibiotic had not been entered into the computer and therefore a correction medication administration sheet was not printed out. The DON stated the resident was without signs or symptoms of an acute UTI but the physician wanted him to receive an IV antibiotic. It was determined at the emergency room that the wrong antibiotic had been initially ordered and the resident was switched to and received IV Rocaphin. The resident returned to the facility without incident.</p> <p>The DON, AIT, and Administrator were notified of the deficient practice on 11/19/14 at 3:00 pm. No additional information was provided that resolved the concerns.</p>	F 333	<ul style="list-style-type: none"> <li>• How will you identify other residents have the potential to be affected by the same deficient practice and what corrective actions(s) will be taken? <ul style="list-style-type: none"> <li>o All medication orders will be reviewed by the admitting nurse and the RHIM the DNS will perform a 24 hour chart check to ensure medication order and accuracy.</li> <li>o Current Residents charts will be reviewed by the DNS, and RHIM to ensure that all orders are accurate and method of delivery included in the MARS.</li> <li>o A 72 hour chart check will be performed by each member of the IDT to ensure that all aspects of the Residents care has been identified.</li> </ul> </li> <li>• What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur <ul style="list-style-type: none"> <li>o Medication Error Analysis Tool (MEAT) process will be used by the DNS (see F-281).</li> <li>o In-service to nursing staff on 12/15/14 by Pharm D regarding prevention of</li> </ul> </li> </ul>	

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			<p>medications errors.</p> <ul style="list-style-type: none"> <li>o Nurses and RHIT were in-serviced on 12/15/14 reviewing the "Physician Order Processing Procedure" to ensure that all steps are completed on all new orders.</li> <li>o Progressive discipline may be used to enforce the policy and procedures and standards of care for Residents.</li> </ul> <p>• Indicate how the facility plans to monitor performance to ensure the corrective actions(s) are effective and compliance is sustained</p> <ul style="list-style-type: none"> <li>o New physician orders will be processed per the Physician Order Processing Procedure and monitored by the DNS for accuracy.</li> <li>o New orders will be processed using the 24 hour check procedure by the night nurse daily.</li> <li>o The DNS will monitor all new orders for accuracy weekly x 4, every 2 weeks x 2 and monthly x 3.</li> </ul>		

January 26, 2015

RECEIVED  
JAN 29 2015

FACILITY STANDARDS

Addendum to F157 plan of Correction:

The Bell Mountain Interdisciplinary Team (IDT) will review all incidents and Occurrences daily in morning stand-up meeting for completeness of the report and notification of the physician and family of the incident. The DNS will follow-up with the reporting nurse every time a report is not complete, and will document on the Incident report of any follow up that was done to complete the report. Reviewing of Incident reports will be a daily ongoing process.

The Wander Guard system is checked every shift for correct function and documented by the assigned CNA on their log. Completed logs are given to the DNS for review for completeness. DNS will discuss with lead CNA whenever documentation is incomplete. This process started December 19, 2014 and will be on going.

*Nadine Juarez L.N.H.A. 1/26/2015*

C268 Dietary Supervision:

Bell Mountain has hired a Dietary manager who is in classes now for her CDM and will be completed with that course on or around December 12, 2015. In the meantime the Dietician will continue to be here 12 hours a week to supervise and she is available by phone and text as well throughout the week or weekends. Bell Mountain Village is requesting a waiver for our Dietary Manager until she receives her CDM.

*Nadine Juarez L.N.H.A. 2/5/2015*

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001050	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 11/19/2014
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NAME OF PROVIDER OR SUPPLIER  BELL MOUNTAIN VILLAGE & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 706 SOUTH MAIN STREET HAILEY, ID 83333
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were: Arnold Rosling, RN, BSN, QIDP Lorraine Hutton, RN</p> <p>The survey team entered the facility on November 12, 2014 and exited on November 19, 2014.</p>	C 000	<p style="text-align: center;">FACILITY C</p>	
C 173	<p>02.100, 12,d Immediate Notification of Physician of Injury</p> <p>d. The physician shall be immediately notified regarding any patient/resident injury or accident when there are significant changes requiring intervention or assessment. This Rule is not met as evidenced by; Refer to F157 as it relates to physician notification.</p>	C 173	C173: Refer to F157	12/23/14
C 268	<p>02.107,01 Dietary Service</p> <p>107. DIETARY SERVICE.</p> <p>01. Dietary Supervision. A qualified food service supervisor shall be designated by the administrator to be in charge of the dietary department. This person shall: This Rule is not met as evidenced by: Based on a complaint from the community and staff interview, it was determined that the dietary manager failed to meet the State of Idaho qualifications to be the food service supervisor.</p>	C 268	<p>C-268 Dietary Service</p> <ul style="list-style-type: none"> <li>• What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice                             <ul style="list-style-type: none"> <li>o No individual residents were named as being affected.</li> </ul> </li> <li>• How will you identify other residents how have the potential to be affected by the same deficient</li> </ul>	

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *CFO* (X6) DATE: 1-26-2015

STATE FORM 6899 Z30G11 If continuation sheet 1 of 3

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001050	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 11/19/2014
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C 268	Continued From page 1 This had the potential to affect all residents in the facility. Findings include:  A complaint was filed with the state agency about the palatability of food the resident eat. During the investigation It was discovered the food service supervisor did not meet the qualification criteria to be designated as the food service supervisor.  The administrator in training was informed 11/14/14 at 11:45 a.m. No further information was provided.	C 268	practice and what corrective actions(s) will be taken o All residents had the potential to be affected.  • What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur o The Dietary Manager was enrolled in the Certified Dietary Manager's course online on 11/21/14. o Any future Dietary manager will be screened for completion of the Certified Dietary Manager's course.	
C 784	02.200,03,b Resident Needs Identified  b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Refer to F309 as it relates to resident care and services.	C 784	• Indicate how the facility plans to monitor performance to ensure the corrective actions(s) are effective and compliance is sustained o All Dietary Managers will be CDM Certified upon hire.	
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered  iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F281 as it relates to not following nursing standards of practice.	C 788	C784: Refer to F309  C788: Refer to F281	12/23/14  12/23/14

*See addendum dated 2/5/2015 AS/...*

Bureau of Facility Standards

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C 790	Continued From page 2	C 790		
C 790	02.200,03,b,vi Protection from Injury/Accidents  vi. Protection from accident or injury; This Rule Is not met as evidenced by: Refer to F323 as it relates to accident and injury prevention	C 790	C790: Refer to F323	12/23/14
C 798	02.200,04,a Medication Administration - Written Orders  04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following:  a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule Is not met as evidenced by: Refer to F 333 as it relates to medications not being administered according to physician's orders.	C 798	C798: Refer to F333	12/23/14



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

January 2, 2015

FILE COPY

Tobi L. Lucero, Administrator  
Bell Mountain Village & Care Center  
706 South Main Street  
Hailey, ID 83333-8400

Provider #: 135069

Dear Ms. Lucero:

On November 19, 2014, a Complaint Investigation survey was conducted at Bell Mountain Village & Care Center. Arnold Rosling, R.N., Q.I.D.P. and Lorraine Hutton, R.N. conducted the complaint investigation. The complaint was investigated in conjunction with four other complaints. The survey team entered the facility on November 12, 2014 and exited on November 14, 2014.

The following documentation was reviewed:

- Staff's disciplinary reports for January 2014 through October 2014;
- Incident and accident reports from January 2014 through November 14, 2014;
- In-service training completed from January 2014 to November 14, 2014;
- Grievance reports and Resident Counsel minutes for January 2014 through October 2014; and
- Clinical records for eight residents, which included the resident identified in the complaint.

Interviews were conducted with the following personnel:

- Two licensed nurses;
- Four CNAs;
- Director of Nursing Services; and
- Administrator and Administrator in Training.

Tobi L. Lucero, Administrator  
January 2, 2015  
Page 2 of 2

The complaint allegations, findings and conclusions are as follows:

**Complaint #6351**

**ALLEGATION:**

The complainant stated that CNAs "on the first shift" took an identified resident's blood pressure at 5:30 p.m. and it was 198/110. The aide reported the blood pressure to the charge nurse who told the aide she thought the blood pressure was inaccurate and did not check the resident. At 7:00 p.m., the identified nurse reported the resident's high blood pressure to the next shift and said it needed to be rechecked. The nurse on the next shift did not check the resident's blood pressure until 3:00 a.m. At that time, the resident was in respiratory distress and was transferred to the hospital where the resident was found to have aspiration pneumonia and was hospitalized for several days before returning to the facility on comfort care. The resident died within a couple of weeks.

**FINDINGS:**

Based on the records reviewed and staff interviews, it was determined the facility failed to ensure licensed nurses assessed and monitored residents when CNAs notified them of abnormal vital signs and other observations. The complaint was substantiated and a deficiency written at F309.

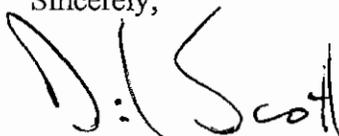
**CONCLUSIONS:**

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

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

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626, Option #2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



DAVID SCOTT, R.N., Supervisor  
Long Term Care

DS/dmj



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

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

FILE COPY

February 11, 2015

Tobi L. Lucero, Administrator  
Bell Mountain Village & Care Center  
706 South Main Street  
Hailey, ID 83333-8400

Provider #: 135069

Dear Ms. Lucero:

On **November 19, 2014**, an unannounced on-site complaint survey was conducted at Bell Mountain Village & Care Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #6353**

**ALLEGATION #1:**

Significant resident events are not appropriately reported, documented or responded to.

**FINDINGS #1:**

During the investigation, incident and accident reports and patient records were reviewed and staff interviews were conducted with the following results:

Incident and accident reports from January 2014 through November 14, 2014, were reviewed. The reports did not consistently demonstrate significant resident events were appropriately reported, documented or responded to. Examples included, but were not limited to, the following:

On January 26, 2014, at 6:30 p.m. the resident was found outside the facility front door, at the end of the ramp, on her knees in the snow.

Tobi L. Lucero, Administrator  
February 11, 2015  
Page 2 of 7

The report documented the physician was notified on January 27, 2014, at 9:31 a.m., fourteen hours after the resident was found in the snow. Additionally, the report stated the family was notified on January 26, 2014, at 8:30 a.m., which was prior to the incident. No other documentation was present related to the actual date and time of the family notification.

The Administrator in Training (AIT) and the Director of Nursing Services (DoN) were interviewed on November 14, 2014, at 11:45 a.m. They stated they had no additional information other than what was documented in the incident report.

The facility failed to ensure the resident's physician and family were notified of the incident in a timely manner and that accurate documentation was kept.

The facility's incident and accident reports also documented that no less than three residents had experienced falls. The incident and accident reports and the corresponding residents' records did not include documentation that thorough investigation, including root cause analysis, had been conducted related to residents' falls. For example, a resident's incident reports, dated January 1, 2014 through February 2, 2014, documented the resident experienced two non-injury falls on January 1, 2014 and January 22, 2014, and a fall with pelvic fractures and hospitalization on February 2, 2014.

The resident's record was reviewed. Her February 2, 2014, nursing notes timed 1:20 a.m. documented "... heard a crash and resident was yelling out. Resident was found on the floor in a puddle of urine, complained of pain, was sent to the emergency room where she was hospitalized with a fractured pelvis."

While appropriate medical care was provided to the resident, the incident and accident reports dated January 1, 2014, January 22, 2014 and February 2, 2014, did not include documentation that thorough investigation, including root cause analysis, had been conducted or that the effectiveness of previous interventions had been evaluated in light of subsequent falls. Additionally, the resident's incident reports documented she continued to fall after she was hospitalized. The incident reports documented falls on February 14, 2014, March 5, 2014, April 17, 2014, May 16, 2014, May 19, 2014 and June 9, 2014. None of the reports included documentation that thorough investigation, including root cause analysis, had been conducted or that the effectiveness of previous interventions had been evaluated in light of subsequent falls.

On November 13, 2014, at 11:25 a.m., the DoN and AIT were interviewed. The DoN was not able to confirm that the root cause of all falls and contributing factors were formally discussed and documented.

The facility failed to ensure thorough investigations were completed and appropriate corrective action had been taken in response to incidents.

Additionally, eight residents' records were reviewed. One resident's record documented a Certified Nurse Aide (CNA) had taken the residents vital signs on January 16, 2014, and found the resident's blood pressure and pulse to be out of normal range. However, documentation of timely intervention to address the resident's abnormal vital signs could not be found.

On November 13, 2014, at 5:25 a.m., a CNA involved was asked about the incident. The CNA stated she notified the charge nurse that the resident's blood pressure and pulse were high. The charge nurse stated she thought it was an error and the resident's blood pressure was not rechecked. The CNA reported the vital signs to the shift arriving at 7:00 p.m. The CNA stated she was not sure when they checked the resident or took vital signs. The CNA also stated there had been many incidences when two members of the nursing staff had ignored reports from the CNAs. However, the two nursing staff members no longer worked at the facility and the current nursing staff were much better at responding to CNA reports and concerns.

The AIT and DoN were interviewed on November 14, 2014, at 10:30 a.m. The DoN stated they were aware of issues with nursing staff not following up with residents' concerns brought to them by the CNAs, as well as the problems with licensed nurses not documenting events that occurred on their shift. The DoN stated that residents' changes in condition were now written on a 24 hour report and discussed in the daily (Monday - Friday) Stand-up Meeting and actions taken and documentation were now reviewed by the DoN, AIT or designated individual on a daily basis.

The facility failed to consistently demonstrate significant resident events were appropriately reported, documented or responded to. Therefore, the allegation was substantiated and federal and state deficient practices were identified.

#### CONCLUSIONS:

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

#### ALLEGATION #2:

Residents are not provided with appropriate supervision and care planning necessary to keep them safe.

#### FINDINGS #2:

During the investigation, observations and staff interviews were conducted and incident and accident reports, facility policies and patient records were reviewed with the following results:

Observations were conducted on the morning, afternoon, evening and night shifts. During the observations, the following was observed:

On November 12, 2014, at 4:30 p.m., a resident was observed to wander into room 38. The

resident who lived in that room was in her wheelchair with her back to the door. The resident walked to within two feet of the resident in room 38, stood for about 30 seconds and left the room. No staff were present in the area.

On November 13, 2014, at 1:30 p.m., the same resident wandered into room 32. The resident in that room was eating her lunch when the other resident entered the room. A CNA entered and escorted the resident out of the room. The CNA asked the resident what he wanted. He indicated he was looking for a bed. The CNA then escorted him to his room so he could lie down.

The resident's September 21, 2014, care plan was reviewed. The plan did not include interventions related to his intrusive wandering. Additionally, the facility's "CNA Guide" for the resident was reviewed. Under the "Behavior/Mental" heading, "Goes into other resident's rooms" was listed. Also, "Wanders" and "Elopement Risk" were checked. However, no interventions were documented related to these behaviors.

The DoN and AIT were informed of the issue on November 14, 2014, at 11:45 a.m. The facility did not have a policy on dealing with the types of behavior that the resident exhibited and there was no evidence of a supervision plan for the resident who wandered intrusively throughout the facility.

Additionally, incident and accident reports from January 2014 through November 14, 2014 were reviewed. The reports documented residents had experienced adverse events due to a lack of appropriate supervision. Examples included, but were not limited to, the following:

An incident report dated January 26, 2014, documented a resident was found outside the facility front door, at the end of the ramp, on her knees in the snow at 6:30 p.m. The investigation report documented the resident was observed at dinner at 6:00 p.m. The resident left the dining room independently in her wheelchair. At approximately 6:30 p.m., the Registered Nurse (RN) heard someone yelling, "help." The RN and a CNA went looking for who was yelling and were able to find the resident outside the facility kneeling in the snow after falling out of the wheelchair.

The Administrator in Training (AIT) and the Director of Nursing Services (DoN) were interviewed on November 14, 2014, at 11:45 a.m. They stated they had no additional information other than what was documented in the incident report.

The facility failed to adequately supervise the resident who was able to exit the building and ultimately fall out of her wheelchair into the snow.

Another resident's incident report documented on November 1, 2014, at 8:30 p.m., the resident "was laying {sic} on the floor in front of her wheelchair with her left leg caught in an awkward position." The resident was transported to the hospital at 9:00 p.m.

The hospital's emergency report documented the resident did not have a fracture. However, the resident did have a skin tear that was treated and returned to the facility. The resident returned to the facility at 11:00 p.m. with a dressing over the leg injury.

The facility's corresponding investigative report into the incident documented on November 1, 2014, at about 7:30 p.m., the resident was taken to her room after dinner. The CNA left the room and closed the door. The report documented the "door was closed to help prevent possible intrusion by a resident, {the other resident's name} during a particularly agitated state."

The DoN and AIT were asked about the incident on November 14, 2014, at 11:45 a.m. They stated the resident was not unattended for more than a couple minutes. However, all the documentation indicated the resident was unattended for up to one hour. The staff were busy with an aggressive resident and it could not be determined what facility staff were doing from 7:30 p.m. to 8:30 p.m., when the resident, who was unattended and had her room door closed, was found on the floor in her room.

The facility failed to ensure appropriate supervision and adequate care planning was completed for residents. Therefore, the allegation was substantiated and federal and state deficient practices were identified.

#### CONCLUSIONS:

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

#### ALLEGATION #3:

Residents do not receive medications as ordered.

#### FINDINGS #3:

During the investigation, medication incident reports and medication error analysis tools were reviewed and staff interviews were conducted with the following results:

The facility's medication administration systems, including controlled drug dispensing records, were reviewed. When asked about the systems, licensed nursing staff stated there was always two nurses involved in counting controlled medications at the end of each shift. When asked, all nurses interviewed denied knowledge of missing controlled substances, such as morphine or replacement of controlled substances, such as replacing missing morphine with water.

Additionally, the facility's records were reviewed. Documentation of missing controlled substances, such as morphine, were not present. However, the facility's medication incident reports for January 1, 2014, through November 14, 2014, documented nine medication errors many that were made by one nurse. Two of the nine medication incident reports (dated January

3, 2014 and January 8, 2014) did not include documentation that timely identification and investigation into the incidents. Additionally, six of the nine medication incident reports (dated January 3, 2014, January 8, 2014, January 26, 2014, January 27, 2014, January 28, 2014 and March 5, 2014) did not include documentation that the cause of the medication errors had been analyzed and appropriate action to prevent reoccurrence had been taken. Examples included, but not limited to, the following:

A January 2, 2014, Medication Error Analysis Tool documented a transcription error. The tool documented the resident's order for morphine sulfate was "entered incorrectly as PRN {as needed} not scheduled." The tool documented the resident's reaction to not receiving the scheduled morphine as "Taking more Oxycontin." A subsequent Medication Error Analysis Tool, dated January 26, 2014, documented the same resident was administered 4 mg of Clonazepam instead of the 2 mg ordered by the physician.

A January 18, 2014, Medication Error Analysis Tool documented a transcription error. The tool documented another resident received Atropine Sulfate 1% in her eyes rather than under her tongue as indicated on the prescription sent to the facility by the pharmacy.

During an interview on November 13, 2014, at 12:55 p.m., the DoN and AIT were asked to provide any additional documentation indicating the medication errors had been investigated and corrective action put into place. The DoN provided copies of staff counseling forms for the nurse who was involved in four of the errors in January 2014. The DoN indicated the nurse was not the only staff involved in the errors, but he was the only one for whom she could show consistent corrective action. The DoN was only able to provide investigations with analysis of the errors and corrective action taken for three of the nine errors that occurred.

The facility did not ensure medications were administered as ordered and standards of practice were observed when passing medications. Therefore, the allegation was substantiated and federal and state deficient practices were identified.

#### CONCLUSIONS:

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

#### ALLEGATION #4:

During the night shift, staff sleep while on duty.

#### FINDINGS #4:

During the investigation, observations and staff interviews were conducted with the following results:

Tobi L. Lucero, Administrator  
February 11, 2015  
Page 7 of 7

On November 13, 2014, at 4:00 a.m., an unannounced observation of the facility was conducted. Staff, including the charge nurse and CNAs, were awake. Four CNAs from the night and morning shifts were interviewed. Each of the CNAs stated they had never observed staff sleeping while on duty.

On November 13, 2014, the DoN and the AIT were interviewed. The DoN stated she had received complaints about staff sleeping on the night shift. The DoN stated she did unannounced visits on the night shift during January 2014 and February 2014. She stated she also interviewed other nurses and CNAs. She found no evidence to make her believe that staff slept on duty.

It could not be established that staff slept while on duty. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

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

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option #2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser". The signature is written in a cursive, somewhat stylized font.

LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor  
Long Term Care

LKK/dmj



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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January 2, 2015

FILE COPY

Tobi L. Lucero, Administrator  
Bell Mountain Village & Care Center  
706 South Main Street  
Hailey, ID 83333-8400

Provider #: 135069

Dear Ms. Lucero:

On November 19, 2014, a Complaint Investigation survey was conducted at Bell Mountain Village & Care Center. Arnold Rosling, R.N., Q.I.D.P. and Lorraine Hutton, R.N. conducted the complaint investigation. This complaint was investigated in conjunction with four other complains. The survey team entered the facility on November 12, 2014 and exited on November 14, 2014.

The following documentation was reviewed for January 2014 - November 2014:

- Nursing staff hours;
- Incident and accident reports;
- Grievance reports;
- Completed In-service training; and,
- Clinical records for eight residents, which included the three residents identified in the complaint.

Interviews were conducted with the following:

- One registered nurse;
- Four certified nurse aides;
- Director of Nursing Services (DNS); and
- Administrator and Administrator in Training.

Observations were completed during day, evening and night shifts.

The complaint allegations, findings and conclusions are as follows:

**Complaint #6496**

**ALLEGATION #1:**

The complainant stated two identified nurses do not respond when certified nurse aides (CNAs) report that a resident has fallen. They just say, "Get him back up." The identified nurses do not assess or follow-up with the resident and do not complete incident reports. This occurred with three identified residents:

- a. Resident # 3 fell on the evening shift in February 2014;
- b. Resident # 2 fell on night shift in March 2014; and
- c. Resident # 1 fell while outside in January 2014, in the evening around dinnertime.

The identified nurse did not do an incident report until the next day.

**FINDINGS #1:**

During the complaint investigation, it was determined the facility failed to provide adequate supervision and care planning needed to prevent residents' falls. This was true for a resident identified in the complaint and residents identified during the complaint investigation:

Resident #5 was harmed when she fell, fractured her pelvis and required hospitalization. The resident continued to fall after returning to the facility.

Resident #1 was put at risk for hypothermia and injury when she exited the facility and later found lying face down in the snow.

Resident #7 was placed at risk for harm when she fell and injured her leg while attempting to move away from a resident who was wandering and disturbing other residents in the facility.

Refer to citation at F323.

In addition, it was determined that the identified LNs did not assess residents consistently after falls or with health status changes. The facility was cited at F309 for failure to assess residents. Please refer to details under allegation #4.

**CONCLUSIONS:**

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

**ALLEGATION #2:**

The complaint stated that the identified nurses did not report the falls listed in the complaint to the residents' physicians or family.

FINDINGS #2:

On January 26, 2014, at 6:30 p.m. Resident #1 was found outside the facility's front door, at the end of the ramp, on her knees in the snow. The incident's investigation had multiple typographical errors regarding times. The family was notified on January 26, 2014, at 8:30 a.m. (Note: time is prior to incident.) The physician was not notified until January 27, 2014, at 9:31 a.m., fourteen hours after the resident was found in the snow.

The complainant indicated there was a delay in notifying the family and physician. There was no other documentation to show when they were notified; therefore, the complaint is substantiated. See citation at F157.

CONCLUSIONS:

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

ALLEGATION #3:

An identified nurse (LN) left medications unattended on top of the medication cart, parked at the nurses' station, on May 4, 2014. The LN left the medications on the cart and went into the nurses' office for about 30 minutes. CNA staff reported the unattended medications to the Director of Nursing Services (DNS). The DNS told the CNA to "Just put them away."

FINDINGS #3:

The medication cart was observed frequently during the morning, evening and night shifts. Medications were not observed to be left unattended during any of the observations. During interviews, two CNAs stated that the nurse identified in the complaint would frequently leave medications on top of the cart unattended. They notified the DNS of their concerns. They did not know if the nurse had been counseled, but she had been fired during the summer.

Interviews with the DNS and other administrative staff revealed the identified nurses had been counseled for a variety of practice issues, which were not correct, and she was terminated during the summer.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated two identified nurses do not respond when certified nurse aides (CNAs) report that a resident has fallen. They just say, "Get him back up." The identified nurses do not assess or follow-up with the resident and do not complete incident reports. This occurred with Resident #s 1, 2 and 3.

FINDINGS #4:

Based on records reviewed it could not be determined that Residents #2 and #3 fell in February 2014 and March 2014 and were not assessed by the licensed nurse (LN) on duty. However, during interviews two CNAs stated they had several experiences of notifying two specific LNs of residents' falls and the LNs did not check the residents or follow-up with the residents.

It was determined that another resident, identified during the complaint investigation as Resident #6, had a change in medical condition with an elevated blood pressure and very fast heart rate, the CNA taking the vital signs notified the LN in charge, who was one of the LNs identified in the complaint. The LN failed to evaluate the resident and passed it off to the next shift. The next shift was late in evaluating the resident. When the resident was evaluated, she was transferred to a local emergency room and admitted to the hospital due to a decline in her health status.

Failure to assess the resident in a timely manner put the resident at risk for an unnoticed decline in medical condition. The facility was cited at F309.

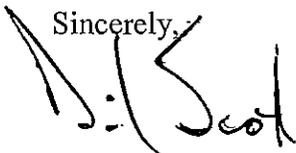
CONCLUSIONS:

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

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

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626, Option #2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "David Scott". The signature is written in a cursive style with a large initial "D" and "S".

DAVID SCOTT, R.N., Supervisor  
Long Term Care

DS/dmj



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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January 2, 2014

FILE COPY

Tobi L. Lucero, Administrator  
Bell Mountain Village & Care Center  
706 South Main Street  
Hailey, ID 83333-8400

Provider #: 135069

Dear Ms. Lucero:

On November 19, 2014, a Complaint Investigation survey was conducted at Bell Mountain Village & Care Center. Arnold Rosling, R.N., Q.I.D.P. and Lorraine Hutton, R.N. conducted the complaint investigation.

This complaint was investigated in conjunction with four other complaints. The survey team entered the facility on November 12, 2014, and exited on November 14, 2014.

The following documentation was reviewed:

- Staffing hours for September, October and November 2014;
- Incident and accident reports from January 2014 through November 14, 2014;
- Resident-to-Resident incidents from January 2014 through November 14, 2014;
- Menus from October 1, 2014 through November 14, 2014;
- Lost items policy;
- In-service training completed from January 2014 to November 14, 2014; and,
- The clinical records for eight residents.

Interviews were conducted with:

- One registered nurse;
- Four CNAs;
- Director of Nursing Services (DNS); and

- Administrator and Administrator in Training.

The complaint allegations, findings and conclusions are as follows:

### **Complaint #6739**

#### **ALLEGATION 1:**

There are two new male residents who are frightening residents, residents #4 and #8. Resident #8 has been in the facility the longest (3-4 weeks). He wanders intrusively into other residents' rooms and tries to get into beds that are not his. He urinates and defecates in residents' rooms and beds and throughout the facility. Occasionally, he will be in the hall naked from the waist down. On Sunday, November 2, 2014, Resident #8 tried to open the door to another resident's room and go inside. The complainant attempted to stop him, but he would not leave, so she called out for staff. However, there was no staff in sight; it was three to five minutes before staff responded. The CNA who responded said Resident #8 just wanted to lie down.

The facility admitted Resident #4 from a locked psych hospital, and he should not be in the nursing home with thirteen other residents over 90 years of age who are fragile elders. He is very tall, young and very fast. He has been reported to hit three CNAs; karate chopped the DoN in the trachea and tried to hit a delivery person. He pulled back with a full fist and would have hit the delivery person, on Friday, if she had not moved her head. Staff will not report the incidents, as they are afraid of losing their jobs.

The staff in the building (receptionist, activities and social services and nursing staff) are not trained to provide care to these types of residents.

There is not enough staff in the facility to meet residents' needs and supervise these two men. It is not fair or safe that the residents have to put up with these two men and their behaviors.

#### **FINDINGS #1:**

The care plan developed by the facility on October 27, 2014, for Resident #4 failed to include a plan or interventions for behaviors or psychoactive medications.

The undated "Bell Mountain CNA Guide" documented that the resident had behaviors of, "Agitated/Anxious, Aggressive, Physical, Wanders, Intrusive and Elopement risk."

The facility had electronic medical records. The behavior documentation by staff relates to the information on the MDS and was not set up for documenting on specific interventions or the resident's response to interventions. The documentation revealed the resident had behaviors on the following dates:

October 30, 2014, at 10:53 a.m. contained documentation that the resident was physical towards staff.

November 2, 2014, at 7:28 p.m. contained documentation of adverse behavior regarding toileting.

November 2, 2014, at 7:29 p.m. contained documentation of gestures and threatening mumbles; and

November 9, 2014, at 2:07 p.m. contained documentation of spitting and throwing medications.

Review of the Nursing Progress Notes revealed the resident had more behaviors than what the CNAs had documented. Some examples included:

On October 29, 2014, at 5:26 p.m. the LN documented "Resident became violent with staff today at approximately 1445 (2:45 p.m.) He grabbed a CNA by the arm and twisted it up and forcing her to walk down the hall. Another CNA and RN intervened to get CNA out of residents grip... He then began grabbing silverware off the tables... Resident was able to grab a butter knife and took off out of the dining area. RN tried to get resident to give her the knife but resident would not release the knife. RN was able to slide knife out of resident's hand. Resident then walked down the hall, saw another CNA, held his hand up to her throat then dropped his hands. Resident was calm after that."

On November 10, 2014, at 6:55 a.m. the LN documented "The resident was one on one from 7pm to 11pm, one on one from 3am - 7am, R/T (related to) fall risk, grabing (sic) people, going in other peoples (sic) rooms, fall risk to other resident."

On November 10, 2014, at 12:36 p.m. the LN documented "Resident has been one on one care this shift with a staff member at his side at all times... Is incontinent of bowel and bladder due to confusion and refusal to sit on the toilet due to cognitive issues..."

The resident was observed by surveyors from November 12, 2014, through November 14, 2014. The resident had a one-to-one during the day and was observed with the night RN during the early morning observation. The resident did not exhibit any aggressive behaviors, wandered but was easily redirected. The resident's wife was seen interacting with the resident. On November 14, 2014, there was a resident-to-resident altercation with Resident #4 and another resident.

The DNS and Assistant Administrator were interviewed on November 14, 2014, at 11:45 a.m. about the resident's behaviors, documentation, behavior plan and policies for residents with behaviors. The facility does not have policies for addressing behaviors. The facility's staff interacts with Resident #4 well, but there was no treatment plan other than the treatment plan he came with, which did not provide sufficient direction for staff. No further information was provided.

The September 21, 2014, care plan for Resident #8 was reviewed. There was no plan addressing the resident's wandering and going into other residents' rooms.

The "Bell Mountain CNA Guide" was reviewed. There was documentation under the heading "Behavior/Mental" annotating "goes into other residents' rooms." In addition, "Wanders" and "Elopement Risk" were checked. There were no interventions for when the resident exhibited behaviors.

During the survey, the resident was observed going into other residents' rooms twice. On November 12, 2014, at 4:30 p.m. the resident was observed to wander into room #38, where a resident was in her wheelchair with her back to the door. The resident walked to within two feet of the female resident, stood for about 30 seconds, and then left the room. No staff was in the area.

On November 13, 2014, at 1:30 p.m. Resident #8 wandered into room #32, the resident was eating her lunch when he came in. A CNA escorted Resident #8 out of the room. She asked him what he wanted, and he indicated he was looking for a bed. The aide took him to his room and he layed down.

The DNS and Assistant Administrator were informed on November 14, 2014, at 11:45 a.m. The facility did not have a policy addressing the type of behaviors that Resident #8 exhibited. The resident wandered, and there was a lack of supervision related to him going into other residents' rooms. No further information was provided.

The complaint was substantiated and citations were written at F323 and F329.

#### CONCLUSIONS:

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

#### ALLEGATION #2:

The quality of the food has declined since the cooks have changed; lots of frozen food covered with cream of mushroom soup.

#### FINDINGS #2:

Observations of three meals were completed during the complaint investigation. These were the lunch meals on November 12, 2014 and November 13, 2014, and the breakfast meal on November 13, 2014. The meals looked palatable and no complaints were voiced when residents were asked about the meals.

The resident council minutes were reviewed for May 10, 2014, June 17, 2014, August 17, 2014,

September 15, 2014 and October 18, 2014. These minutes reflected satisfaction in the menus and meals from the residents who attended. The only request asked that the "heavy meal" would occur at lunchtime. The October meeting reflected satisfaction from the residents that this had occurred.

An interview was completed on November 13, 2014, at 10:20 a.m. with the acting administrator about the dietary manager. The manager was appointed near the first of October, when the previous manager quit without notice. The acting administrator was informed that the current manager does not meet the criteria to manage the kitchen. See State citation C268 for more information.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #3:

Clothes of Resident #1 continue to come up missing, which included three pajama tops that she believes were put in the garbage. She labels them, but they disappear. Her glasses and back-up glasses are missing.

Resident #1 is left in her clothes at night, when sleeping.

#### FINDINGS #3:

The social worker was interviewed about the lost items on November 13, 2014, at 11:05 a.m. She provided a copy of the grievance the family member filed with the facility.

The social worker went to the resident's room after receiving the complaint and completed a search for the missing items. She was able to find everything on the list of lost clothing except a pajama top. She is still searching for the item.

She educated laundry workers and CNAs to mark clothing and place items in the right resident's closet.

The resident's glasses showed up on the resident's face one day. The second pair had not been located at the time of the survey. The social worker indicated that she had gone through the laundry checking to see if they could be located, but had not located the pair of glasses. The plan was to replace the glasses or reimburse the family for the items the facility was not able to locate.

The survey team entered the facility November 13, 2014, at 4:30 a.m. The early entry was to see if residents were still dressed in their daytime clothing. There was only one resident who had his/her daytime clothing on. The CNAs working that night stated the resident preferred not to

put nightclothes on when she was placed in bed. None of the other residents were in their daytime clothes.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Resident #7 was sent to the emergency room (ER) on October 31, 2014, during the evening shift, as she fell while waiting for staff that were reportedly occupied with residents #4 and #8. She believes she fell while trying to get up by herself, which is not typical for this resident, and she fractured her foot.

The staff in the building (receptionist, activities, social services & nursing staff) are not trained to provide care to these types of residents, i.e., residents #4 and #8.

There was not enough staff in the facility to meet residents' needs and to supervise these two men. It is not fair that the residents have to tolerate these two men and their behaviors.

FINDINGS #4:

Resident #7 was admitted to the facility on February 14, 2014, with diagnoses of depressive disorder, post fracture right hip, congestive heart failure and cerebral vascular accident.

Based on review of the November 1, 2014, Incident and Accident report, November 1, 2014, Occurrence Report and the Investigative Report submitted to the Bureau of Facility Standards on November 7, 2014, the following information was obtained:

The Investigative Report documented that on November 1, 2014, at about 7:30 p.m. Resident #7 was taken to her room after dinner. The CNA left the room and closed the residents' door. The report documented the "door was closed to help prevent possible intrusion by resident, (resident's name), during a particularly agitated state." The Occurrence Report documented the other resident had already physically attacked a staff member. The Investigative Report documented the DNS was providing one-on-one supervision for the resident exhibiting behaviors.

The Investigative Report documented the facility had twenty-two residents. There were two CNAs and one LPN on this shift. The DNS was providing one-to-one supervision for the resident exhibiting behaviors. The schedule for November 1, 2014, was reviewed and one of the CNAs was scheduled to work from 5:00 p.m. to 9:00 p.m.

The I&A documented on November 1, 2014, at 8:30 p.m. Resident #7 "was laying on the floor in front of her wheelchair with her left leg caught in an awkward position." The resident was

transported to the hospital at 9:00 p.m.

The hospital's emergency report documented the resident did not have a fracture but did have a skin tear that was treated, and the resident returned to the facility at 11:00 p.m. with a dressing over the leg's injury.

The DNS and Assistant Administrator were interviewed on November 14, 2014, at 11:45 a.m. They indicated the resident was not unattended for more than a couple minutes; however, the facility's documentation reveals the resident was unattended for up to one hour. The staff were busy with an aggressive resident, and the documentation was vague with what the facility was doing from 7:30 p.m. to 8:30 p.m., when Resident #7, who was unattended and had her room door closed, was found on the floor in her room.

The complaint was substantiated and a citation was written at F323.

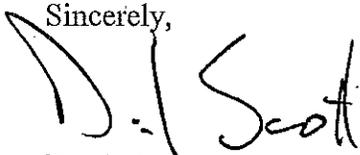
**CONCLUSIONS:**

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

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

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large initial "D" and a stylized "S".

DAVID SCOTT, R.N., Supervisor  
Long Term Care

DS/dmj