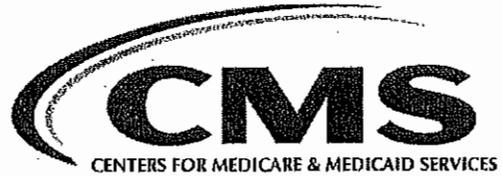


DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Western Division of Survey and Certification  
Seattle Regional Office  
701 Fifth Avenue, Suite 1600  
Seattle, WA 98104



**NOTICE OF TERMINATION OF  
MEDICARE PROVIDER AGREEMENT  
IMPORTANT NOTICE – PLEASE READ CAREFULLY**

December 4, 2014

Charles Lloyd, Jr., Administrator  
Mountain View Center for Geriatric Psychiatry  
500 Polk Street East  
Kimberly, ID 83341

CMS Certification Number: 13-4014

Re: Complaint survey completed 08/11/2014 and CoP Not Met  
Revisit survey 11/20/2014 and CoPs still not met  
**Termination from the Medicare program effective 12/19/2014**  
Appeal rights

Dear Mr. Lloyd:

After careful review of the facts, the Centers for Medicare and Medicaid Services (CMS) has determined that Mountain View Center for Geriatric Psychiatry no longer meets the requirements for participation as a provider of services in the Medicare program established under Title XVIII of the Social Security Act. This is to notify you that effective **December 19, 2014** the Secretary of the Department of Health and Human Services intends to terminate its provider agreement with Mountain View Center for Geriatric Psychiatry. We will publish a legal notice in the local newspaper 15 days prior to the termination date.

I. BACKGROUND

To participate as a provider of services in the Medicare and Medicaid Programs, a psychiatric hospital must meet all of the Conditions of Participation (CoP) established by the Secretary of Health and Human Services. When a psychiatric hospital is found to be out of compliance with the Medicare Conditions of Participation, the facility no longer meets the requirements for participation as a provider of services in the Medicare program.

The Social Security Act Section 1866 authorizes the Secretary to terminate a psychiatric hospital's Medicare provider agreement if the psychiatric hospital no longer meets the regulatory requirements for a psychiatric hospital. Regulations at 42 CFR § 489.53 authorize CMS to terminate Medicare provider agreements when a provider, such as Mountain View Center for Geriatric Psychiatry, no longer meets the Conditions of Participation.

On August 11, 2014, the Idaho Bureau of Facility Standards (State survey agency) completed a complaint survey at Mountain View Center for Geriatric Psychiatry and notified you that the Medicare Condition of Participation (CoP) Patient Rights (42 CFR § 482.13) was not met. Briefly, the psychiatric hospital did not monitor the quality and appropriateness of services when it failed to ensure that hospital staff administered medications in accordance with physician orders and protected patients from injury.

On October 6, 2014, the State survey agency completed a revisit survey at the psychiatric hospital and notified you about an Immediate Jeopardy finding regarding the Medicare CoP Patient Rights (42 CFR § 482.13). Briefly, the psychiatric hospital did not monitor the quality and appropriateness of services when it failed to ensure comprehensive patient assessments were conducted by the medical, psychiatric, and nursing staff upon admission and throughout patients' hospitalization. The Immediate Jeopardy was not removed by the end of the survey. On October 27, 2014, a second revisit survey determined that the Immediate Jeopardy had been abated but the Medicare hospital Condition of Participation was still not met.

On November 20, 2014, the State survey agency completed a third revisit survey at Mountain View Center for Geriatric Psychiatry and notified you that the Medicare Conditions of Participation were still not met. Briefly, the hospital's lack of initial and ongoing patient assessments and lack of appropriate interventions resulted in the deterioration of a patient's respiratory status and eventual transfer to an acute hospital's emergency department. The following Conditions of Participation are not met:

42 CFR § 482.13      Patient Rights

42 CFR § 482.23      Nursing Services

These deficiencies limit the capacity of Mountain View Center for Geriatric Psychiatry to furnish services of an adequate level and quality. The details of the above deficiencies were sent to you by the State survey agency.

## II. PUBLIC NOTICE OF TERMINATION

In accordance with 42 CFR § 489.53(d), legal notice of our action will be published in the local newspaper (Times-News) on December 4, 2014.

## III. APPEAL RIGHTS

If you do not agree with this determination, you may request a hearing before an administrative law judge (ALJ) of the Departmental Appeals Board in accordance with 42 CFR §§ 498.40 through 498.78. A request for hearing must be filed **electronically** no later than **sixty (60) calendar days** after the date you receive this notice. 42 CFR § 498.40. You should file your request for an appeal (accompanied by a copy of this letter) through the Departmental Appeals Board Electronic Filing System website (DAB E-file) at <https://dab.efile.hhs.gov>. Please note: All documents must be submitted in Portable

Document Format (“pdf”). You are **required** to e-file your appeal request unless you do not have access to a computer or internet service. In such circumstances, you may file in writing, but must provide an explanation as to why you cannot file submissions electronically and request a waiver from e-filing in the mailed copy of your request for a hearing. A written request for appeals must also be filed no later than sixty (60) calendar days from the date you receive this notice, and must be submitted to the following address:

Department of Health and Human Services  
Departmental Appeals Board, MS 6132  
Civil Remedies Division  
330 Independence Ave, SW  
Cohen Building, Room G-644  
Washington, D.C. 20201

A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. 42 CFR § 498.40(b)(1). It should also specify the basis for contending that the findings and conclusions are incorrect. 42 CFR § 498.40(b)(2). You may be represented by counsel at a hearing at your own expense.

Should you choose to exercise your right to appeal, please forward a copy of that appeal to:

Chief Counsel  
Office of General Counsel, DHHS  
701 Fifth Avenue, Suite 1600  
Seattle, WA 98104

#### IV. PAYMENT FOR MEDICARE PATIENTS AFTER TERMINATION

To facilitate the appropriate movement and placement of Medicare patients from the hospital upon termination of your Medicare provider agreement, payments for those Medicare patients who were admitted to your facility prior to December 19, 2014 and who remained in your facility on December 19, 2014, may be permitted for up to a maximum of thirty (30) days after the effective date of termination in accordance with 42 CFR § 489.55(a). Under 42 CFR § 441.11(a), Medicaid payments may also continue for services rendered for up to a maximum of 30 days following the termination date.

#### V. REINSTATEMENT AFTER TERMINATION (CFR § 489.57)

When a provider agreement has been terminated by CMS under CFR § 489.53, a new agreement with that provider will not be accepted unless CMS finds: (a) that the reason for termination of the previous agreement has been removed and there is reasonable assurance that it will not recur; and (b) that the provider has fulfilled, or has made satisfactory arrangements to fulfill, all of the statutory and regulatory responsibilities of its previous agreement.

Page 4 – Mr. Lloyd

If you have any questions, please contact Kate Mitchell of my staff at (206) 615-2432 or by email at [Catherine.mitchell@cms.hhs.gov](mailto:Catherine.mitchell@cms.hhs.gov).

Sincerely,

A handwritten signature in black ink that reads "Karen Fuller, Acting". The signature is written in a cursive, flowing style.

Steven Chickering,  
Associate Regional Administrator  
Western Division of Survey & Certification

cc: Idaho Bureau of Facility Standards  
Office of General Counsel, DHHS



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: 700 1670 0011 3315 1651**

December 4, 2014

Charles Lloyd, Administrator  
Mountain View Center For Geriatric Psychiatry  
500 Polk Street East  
Kimberly, ID 83341

RE: Mountain View Center For Geriatric Psychiatry - License #63

Dear Mr. Lloyd:

This is to advise you of the findings of the Medicare/Licensure survey, which was concluded at your facility on November 20, 2014.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies. We have notified CMS Region X that the following Conditions of Participation remain out of compliance:

**42 CFR 482.13      Patient Rights**

**42 CFR 482.23      Nursing Services**

CMS Region X will be in contact with you regarding further actions related to Medicare deficiencies.

Also, enclosed is a Statement of Deficiencies/Plan of Correction, State Form-2567, which describes licensing deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction for the licensing deficiencies.

An acceptable plan of correction (PoC) contains the following elements:

Charles Lloyd, Administrator

December 4, 2014

Page 2 of 2

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the into compliance, and that the remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the State Form-2567.

After you have completed your Plan of Correction, return the original to this office by **December 18, 2014**, and keep a copy for your records.

Please be aware that due to the serious and repetitive nature of the licensure deficiencies, further action may be taken against the hospital's license, if corrections are not promptly achieved and maintained.

Thank you for the courtesies extended to us during our visit. If you have any questions, please write or call this office at (208) 334-6626, option 4.

Sincerely,



SYLVIA CRESWELL

Co-Supervisor

Non-Long Term Care

cc. Kate Mitchell, CMS Region X  
Debra Ransom, R.N., R.H.I.T., Bureau Chief

SC/pt  
Enclosures

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{A 000}	INITIAL COMMENTS  The following deficiencies were cited during the follow up survey at your hospital from 11/17/14 through 11/20/14. Surveyors conducting the survey were:  Susan Costa, RN, HFS Team Leader Nancy Bax, BSN, HFS  Acronyms used in this report include:  ALF - Assisted Living Facility CNA - Certified Nursing Assistant DON - Director of Nursing DPOA - Durable Power of Attorney EHR - electronic health record H&P - History and Physical examination IDG - Inter-disciplinary Group LPN - Licensed Practical Nurse LMSW - Licensed Medical Social Worker LTC - Long Term Care MAR - Medication Administration Record mg - milligram MD - Medical Doctor NP - Nurse Practitioner OT - Occupational Therapy POST - Physician Orders for Scope of Treatment prn - as needed PT - Physical Therapy Pt - Patient RD - Registered Dietician RN - Registered Nurse SNF - Skilled Nursing Facility	{A 000}			
{A 115}	482.13 PATIENT RIGHTS  A hospital must protect and promote each patient's rights.	{A 115}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 115}	<p>Continued From page 1</p> <p>This CONDITION is not met as evidenced by: Based on observation, patient and staff interview, and review of medical records and facility policies, it was determined the facility failed to ensure patients' rights were protected and promoted. The facility failed to identify, and respond to, patients' initial and ongoing health and safety needs. This resulted in 1) a patient becoming unresponsive due to medication overdose and emergency transport of the patient to a local ED, 2) lack of treatment for a patient experiencing mental anguish due to major depression, and 3) the failure of the hospital to ensure patients' advance directives of Resuscitation or Do Not Resuscitate, were immediately identifiable if an emergency situation occurred. Findings include:</p> <ol style="list-style-type: none"> <li>1. Refer to A132 as it relates to the facility's failure to ensure that Advance Directives were accurate and authenticated, to quickly identify the wishes of the patient.</li> <li>2. Refer to A144 as it relates to the facility's failure to ensure interventions were implemented in a timely manner as a patient's health status was deteriorating.</li> <li>3. Refer to A145 as it relates to the facility's failure to ensure patients were provided services related to their mental illness.</li> <li>4. Refer to A385 as it relates to the failure of the facility to ensure nursing staff provided appropriate assessments and implemented interventions as a patient's condition deteriorated.</li> <li>5. Refer to A454 as it relates to the failure of the nursing staff to receive and transcribe physician</li> </ol>	{A 115}		



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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  134014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 11/20/2014
NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY		STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341		
(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
A 132	<p>Continued From page 3</p> <p>"IDAHO PHYSICIAN ORDERS FOR SCOPE OF TREATMENT" (POST). Section A of the form included a check mark next to "Do Not Resuscitate (No Code): Allow Natural Death; Patient does not want any heroic or life-saving measures." The POST form was signed by Patient #1's son on 10/03/14, and signed by his physician on 10/21/14.</p> <p>The facility utilized green binders to hold medical records for current patients. Each patient's binder was labeled with the patient's name, physician's name and date of admission. The front of Patient #1's binder included a bright green sticker labeled "ADVANCE DIRECTIVES". The label included a check mark next to "DO NOT RESUSCITATE" and "DURABLE POWER OF ATTORNEY FOR HEALTH CARE". The word "Committed" was hand written on the bright green label.</p> <p>During an interview on 11/18/14 at 10:00 AM, the DON stated when a patient is admitted to the facility on an involuntary status, they have to be a full code, meaning in the event of cardiac or respiratory arrest, resuscitation efforts would be initiated and emergency medical services called for transport to an acute care hospital.</p> <p>During an interview on 11/18/14 at 10:15 AM, the RN assigned to Patient #1 was asked about his status related to resuscitation. She looked at his POST form and stated it was "Do Not Resuscitate". She was then asked why the word "Committed" was written on the bright green sticker on the front of his record. She stated, "I think if they are committed they are a full code, but I'd have to check the policy." She looked through the legal documents in Patient #1's</p>	A 132		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST</b> <b>KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 132	<p>Continued From page 4 record for 8 minutes, and then stated, "I'm not sure. I'd have to read all this."</p> <p>Johns Hopkins Medicine website, accessed 11/24/14, stated when cardiac arrest occurs, "Response time is critical, with the death of all other brain and bodily functions occurring in just four to six minutes following cardiac death ... After ten minutes, survival is unlikely".</p> <p>The RN was asked how she would proceed if she found Patient #1 on the floor without a pulse or respirations. She stated she would check his wrist band to determine his resuscitation status, so she would not have to walk away from him.</p> <p>On 11/18/14 at 11:05 AM, Patient #1's wrist band was examined. It did not include his resuscitation status.</p> <p>During an interview on 11/18/14 at 10:25 AM, the Director of Social Services stated Patient #1's situation was unusual. She stated he had a guardian assigned by the state to make decisions related to his medical care, however, the guardian allowed Patient #1's son to make the decision related to his resuscitation status. The Director of Social Services reviewed Patient #1's record and was unable to find documentation stating the son was authorized to determine his resuscitation status. She stated she did not know why the word "Committed" was written on the sticker and she confirmed it resulted in confusion to the facility staff as to Patient #1's resuscitation status.</p> <p>Patient #1's resuscitation status was not clearly documented to allow the facility staff to respond appropriately in the event of cardiac or respiratory</p>	A 132		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 132	<p>Continued From page 5 arrest.</p> <p>2. Patient #3 was a 77 year old female admitted to the facility on 11/17/14, for psychiatric care related to acute manic phase of her bipolar disorder.</p> <p>Patient #3's medical record included a form titled, "IDAHO PHYSICIAN ORDERS FOR SCOPE OF TREATMENT" (POST). Section A of the form included a check mark next to "Resuscitate (Full Code)". The POST form did not include patient or physician signatures.</p> <p>The front of Patient #3's binder included a bright green sticker labeled "ADVANCE DIRECTIVES". The label included a check mark next to "DO NOT RESUSCITATE" or "DNR."</p> <p>During an interview on 11/18/14 at 10:30 AM, the Director of Social Services and the DON reviewed Patient #3's record. They both confirmed the green sticker on the front of her record indicated she was a "DNR." The DON stated she did not know why the sticker indicated DNR, as she was on a Designated Examiner Hold status, and was a full code according to the facility policy. The Director of Social Services confirmed her response and stated the sticker should not have indicated DNR.</p> <p>The resuscitation status indicated on Patient #3's medical record was incorrect.</p> <p>3. Patient #2 was a 61 year old male admitted to the facility on 9/11/14 for psychiatric care related to schizophrenia with acute exacerbation and psychosis.</p>	A 132		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 132	<p>Continued From page 6</p> <p>Patient #2's medical record included a form titled, "IDAHO PHYSICIAN ORDERS FOR SCOPE OF TREATMENT" (POST). Section A of the form included a check mark next to "Do Not Resuscitate (No Code): Allow Natural Death; Patient does not want any heroic or life-saving measures." The line next to "Patient/Surrogate Signature" was blank. The physician signature line was signed by the psychiatric NP, and dated 9/12/14.</p> <p>The POST form indicated the basis for the Do Not Resuscitate order was the patient's known preference and his living will, however his medical record did not include a living will document.</p> <p>A hand-written note at the bottom of the form stated the form was discussed with Patient #2's spouse on 9/10/14, which was the day before he was admitted to the facility. However, Patient #2's medical record did not contain documentation to indicate an attempt had been made to obtain his wife's signature on the form.</p> <p>During an interview on 11/18/14 at 10:40 AM, the Director of Social Services and the DON reviewed Patient #2's record, and confirmed the POST did not include a signature from his spouse. The Director of Social Services stated when a family member is unable to sign the admission and other paperwork, a packet of forms to be signed would be mailed. She stated that probably occurred, and the wife of Patient #2 probably did not return the paperwork. However, she was unable to provide evidence that Patient #2's spouse was sent the paperwork to be signed.</p> <p>Patient #2's POST form was not signed by the</p>	A 132		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 132  {A 144}	<p>Continued From page 7 patient or responsible party. 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING</p> <p>The patient has the right to receive care in a safe setting.</p> <p>This STANDARD is not met as evidenced by: Based on observation, review of medical records, facility policies, and staff interviews, it was determined the hospital failed to ensure care was provided in a safe setting for 1 of 3 current patients (Patient #3) residing in the facility during the survey. As a result of the hospital's systemic failures a patient experienced a medication overdose and became hypoxic and unresponsive, requiring emergency transport to the ED of an acute care hospital. Findings include:</p> <p>Patient #3 was a 77 year old female admitted to the facility on 11/17/14, for psychiatric care related to acute manic phase of her bipolar disorder. Patient #3's 11/17/14 ADMISSION RECORD also included diagnoses of insomnia, hypothyroidism, chronic pain, macular degeneration, COPD, spinal stenosis, and osteoporosis. She was admitted from a SNF where she resided from 11/12/14 to 11/17/14. The SNF and psychiatric hospital are owned by the same corporation. Medical staff at the psychiatric hospital also provide services at the SNF. The same psychiatrist and medical doctor provided oversight of Patient #3's care in both settings.</p> <p>The time of Patient #3's admission was not documented. However, nursing notes from the SNF, dated 11/17/14, documented Patient #3 left</p>	A 132  {A 144}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	<p>Continued From page 8</p> <p>the SNF at 4:15 PM and nursing staff at Mountain View Center for Geriatric Psychiatry began documentation of Patient #3's activity every 15 minutes at 4:45 PM. Therefore, she was admitted between 4:15 PM - 4:45 PM.</p> <p>The hospital's Plan of Correction for deficiencies cited during the 10/06/14 follow-up survey included the use of "High Five" pre-printed standing order forms. The High Five referred to 5 high profile diagnoses requiring special follow-up and special documentation.</p> <p>Patient #3's record included a High Five standing order form for use with patients who have a history of pneumonia, COPD exacerbation, or respiratory failure. It identified Patient #3 as having a history of pneumonia and/or respiratory failure. The form included specific standing orders to be followed. One of the orders stated the outside of Patient #3's medical record chart was to clearly identify that she had a high profile diagnosis which required special follow-up and documentation. However, during the survey her chart was not flagged with that information as per the standing order.</p> <p>During an interview on 11/19/14 beginning at 3:00 PM, the DON reviewed Patient #3's record and confirmed the standing orders were not implemented. She stated Patient #3 was identified as having one of 5 specific high profile diagnoses that required closer monitoring. The DON confirmed the outside of Patient #3's chart did not specifically identify her as having a high profile diagnosis.</p> <p>Patient #3's 11/17/14 admission orders written by the psychiatric NP, included the following</p>	{A 144}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  134014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 11/20/2014
NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY		STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341		
(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
{A 144}	<p>Continued From page 9 scheduled medications:</p> <ul style="list-style-type: none"> <li>- Chlorpromazine (Thorazine), 50 mg, 4 times per day, scheduled at 8:00 AM, 12:00 PM, 5:00 PM and 9:00 PM</li> <li>- Lithium, 300 mg, 2 times per day, scheduled at 8:00 AM and 5:00 PM</li> <li>- Clonazepam, 0.5 mg, 2 times per day, scheduled at 8:00 AM and 5:00 PM</li> <li>- Nicotine Patch 14 mg, once daily, scheduled at 5:00 PM</li> <li>- Synthroid, 75 mcg, once daily, scheduled at 6:00 AM</li> </ul> <p>Patient #3's admission orders also included the following PRN medications:</p> <ul style="list-style-type: none"> <li>- Ativan 1 mg, every 4 hours for anxiety</li> <li>- Tramadol 50 mg, up to 4 times daily for pain</li> <li>- Trazodone 50 mg, as needed at night for sleeplessness</li> <li>- Pro-Air, 2 puffs as needed for reactive airway disease</li> <li>- Flonase, 2 sprays each nostril as needed for runny nose</li> <li>- Calmoseptine cream, apply as needed for excoriation and redness</li> </ul> <p>Patient #3's hospital record included copies of her MAR from the SNF. The copies were faxed to the hospital from the SNF on 11/17/14 at 1:17 PM, prior to her arrival at the facility.</p> <p>The SNF MAR indicated 3 medications were introduced during her 5 day stay at the SNF:</p> <ul style="list-style-type: none"> <li>-Lithium (to treat bipolar disorder) 300 mg, 2 times per day was ordered on 11/14/17, the first dose given at 7:00 PM the same day.</li> </ul>	{A 144}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	<p>Continued From page 10</p> <p>-Clonazepam (to treat anxiety) 0.5 mg, 2 times per day was ordered on 11/16/14, the first dose given at 8:00 PM the same day.</p> <p>Epocrates, an on-line medical resource widely used by health care professionals, was accessed on 11/21/14. It stated Clonazepam should be started at 0.25 mg, 2 times a day and may be increased by 0.25 mg after 1-2 days. Additionally, it stated a lower initial dose should be considered in elderly patients.</p> <p>Drugs.com, another on-line resource widely used by health care professionals for information on medications, was accessed on 11/21/14. It stated Clonazepam doses for elderly patients should start at the low end of the dosing range. Additionally, elderly patients should be observed closely as the drug may cause confusion and over-sedation in the elderly.</p> <p>-Thorazine (to treat psychotic behavior) 50 mg, 4 times per day, was ordered on 11/17/14, however, Patient #3 refused the first dose scheduled at 12:00 PM. Therefore, she had not taken Thorazine prior to her transfer and admission to Mountain View Center for Geriatric Psychiatry.</p> <p>Epocrates stated Thorazine, when prescribed for psychosis, should be started at 10-25 mg, 3 times a day, and may be increased by 20-50 mg per day after 1-2 days. Additionally, it stated when Thorazine is prescribed for elderly patients, it should be started at a lower dosage and increased more slowly.</p> <p>Genus Pharmaceutical is a producer of chlorpromazine. The package insert for</p>	{A 144}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  134014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 11/20/2014
NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY		STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341		
(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
{A 144}	<p>Continued From page 11</p> <p>chlorpromazine, accessed on 11/21/14 on the website www.genuspharma.com, stated the initial dose for adults is usually 25 mg, 3 times a day. It stated for the elderly or debilitated the usual starting dose is one third to one half the adult dose.</p> <p>The website Epocrates contained an on-line resource to check for interactions between medications. The interactions were classified in one of 4 levels:</p> <ul style="list-style-type: none"> <li>- Contraindicated</li> <li>- Avoid/Use Alternative</li> <li>- Monitor/Modify Treatment</li> <li>- Caution Advised</li> </ul> <p>Patient #3's admission medications, as listed above, were entered into the interaction checker on 11/21/14. The results showed the following interactions at the second highest level of severity, Avoid/Use Alternative:</p> <ul style="list-style-type: none"> <li>- Thorazine and Lithium</li> <li>- Thorazine and Trazodone</li> </ul> <p>The results showed the following interactions at the third highest level of severity, Monitor/Modify Treatment:</p> <ul style="list-style-type: none"> <li>- ProAir and Thorazine</li> </ul> <p>The Drugs.com website accessed on 11/21/14, stated using Thorazine and Lithium together may result in increased side effects, including extreme drowsiness.</p> <p>The medications administered to Patient #3 on 11/17/14 at the SNF prior to her transfer included:</p> <ul style="list-style-type: none"> <li>- Lithium 300 mg, at 9:00 AM,</li> <li>- Clonazepam 0.5 mg, at 9:00 AM,</li> </ul>	{A 144}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	<p>Continued From page 12</p> <ul style="list-style-type: none"> <li>- Tramadol 50 mg, at 8:00 AM for leg pain,</li> <li>- Ativan 1 mg, at 1:00 PM for anxiety.</li> </ul> <p>Patient #3's record included an "Admission Nursing Assessment," signed by RN C, the Admissions RN on 11/17/14 at 7:00 PM. The assessment noted Patient #3 was awake, alert, and intermittently confused, with increasing agitation.</p> <p>The narrative section of the Admission Nursing Assessment dated 11/17/14, and signed by RN C, included documentation of Patient #3's mental status. It included "Pt was cooperative [with] admission assessment initially, answered questions freely as the process cont [continued] pt became very non-compliant yelling 'stop leave me alone' hitting and striking out and pulling away from staff [with] more agitation. Several attempts made to cont [continue] assessment were refused and causes increased agitation. Will re-attempt at later time." The admission assessment included a section for vital signs, but all measurements other than an initial blood pressure, temperature, and respiratory rate were refused by Patient #3. Her pulse and oxygen saturation measurements were not performed. Her weight was identified as 104 pounds, her initial blood pressure was 106/80 and her respiratory rate was 18.</p> <p>A nursing note, dated 11/17/14 at 7:04 PM, was completed by RN D, the RN on duty for the day shift (7:00 AM to 7:00 PM). RN D noted Patient #3 was non re-directable, non-approachable, verbally aggressive, and confused.</p> <p>A form titled "15 Minute Mood and Behavior Observation Record," indicated Patient #3's</p>	{A 144}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  134014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 11/20/2014
NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY			STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341		
(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	
{A 144}	<p>Continued From page 13</p> <p>behavior included physical aggression, verbal aggression, and delusions on 11/17/14 from 6:00 PM until 7:45 PM. Additionally, the form indicated she went to her room at 7:15 PM. The entries on the form were completed and initialed by CNA F.</p> <p>Patient #3's MAR documented medications scheduled to be given at 5:00 PM were:</p> <ul style="list-style-type: none"> <li>- Lithium 300 mg</li> <li>- Klonopin 0.5 mg</li> <li>- Thorazine 50 mg</li> <li>- Nicotine Patch, 14 mg</li> </ul> <p>Although Patient #3's MAR had the time of administration for the medications as 5:00 PM, the actual time the medications were administered was not noted. However, the medications were not administered before 5:35 PM. Observations of Medication Pass activities were conducted by the survey team. LPN E was observed administering medications to Patient #1 beginning at 5:25 PM on 11/17/14. Patient #1's medication pass took 10 minutes. LPN E stated she would be administering medications to Patient #3 after she completed Patient #1's medication pass, therefore, the earliest they were administered was after 5:35 PM.</p> <p>Patient #3's MAR documented she received her 9:00 PM scheduled dose of Thorazine 50 mg, but during a phone interview on 11/18/14 beginning at 3:00 PM, RN B confirmed it was given between 8:00 and 8:30 PM. Additionally, RN B stated Patient #3 was awakened to take the Thorazine which she had crushed and mixed with pudding. Based on the time of administration of the medications, Patient #3 received 2 doses of Thorazine 50 mg possibly 2 hours and 25</p>	{A 144}			

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	<p>Continued From page 14</p> <p>minutes apart, but not more than 2 hours and 55 minutes apart. The medication was scheduled to be given 4 hours apart.</p> <p>Patient #3's High Five standing order form, referenced previously, also included the following orders:</p> <ul style="list-style-type: none"> <li>- Patient #3's medical physician was to be contacted immediately if the following was noted: Heart rate persistently greater than baseline, Oxygen saturation persistently below baseline, New or worsening shortness of breath, Respiratory rate persistently greater than baseline, Temperature persistently 1 or more degrees above baseline.</li> </ul> <p>The information below demonstrates that these standing orders were not followed. Patient #3's medical physician was not contacted immediately when her heart rate was elevated, she experienced worsening shortness of breath, and her oxygen saturation levels remained persistently below baseline for approximately 7 hours.</p> <p>The Doctor's Orders and Progress Notes form in Patient #3 record included a telephone order from the NP written on 11/17/14 at 3:30 PM. The note stated the orders were "to be reviewed upon admission." One order was "oxygen 2L/NC to maintain [oxygen] sats at or &gt; 88% (aspiration)."</p> <p>Patient #3's Physician Admission Orders form, completed and signed by RN C, (who was also the hospital Admissions RN), on 11/17/14 at 3:45 PM, included an oxygen protocol which stated "Oxygen per NC titrate to keep sats &gt; 90% or</p>	{A 144}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	<p>Continued From page 15</p> <p>continuously [sic]." The line for M.D. signature and date was blank. The form also included "I, [name of psychiatrist] certify....I also certify that I have reviewed and approved the medical and behavioral care plans."</p> <p>Patient #3's record included a form titled "Weights and Vitals Summary." The form included vital signs as follows:</p> <p>11/17/14 at 7:15 PM, Oxygen saturation of 77% on room air. 11/17/14 at 9:30 PM, Oxygen saturation of 82% with oxygen via nasal cannula (flow rate was not documented). 11/18/14 at 12:12 AM, Oxygen saturation of 82% with oxygen via nasal cannula (flow rate was not documented). 11/18/14 at 1:05 AM, Oxygen saturation of 85% with oxygen via mask. 11/18/14 at 2:30 AM, Oxygen saturation of 80% with oxygen via mask.</p> <p>A blood pressure documented on the form as taken on 11/17/14 at 8:32 PM, was 106/80, and her temperature at the same time was 97.5. There were no further vital signs documented on the vital sign summary sheet.</p> <p>The Mayo clinic website, accessed on 11/26/14, stated a normal oxygen saturation level is 95-100%, and levels below 90% are considered low. Additionally it stated, "In order to function properly, your body needs a certain level of oxygen circulating in the blood to cells and tissues. When this level of oxygen falls below a certain amount, hypoxemia occurs..."</p> <p>Although Patient #3 demonstrated a low oxygen</p>	{A 144}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	<p>Continued From page 16</p> <p>saturation level over several hours, her medical record did not include documentation of her respiratory rate, or an assessment of the quality of her respirations.</p> <p>Her blood pressure and temperature were documented at 8:32 PM, however a form titled "15 minute check, Alarm Check, and hour of sleep documentation," with entries by CNA F, indicated Patient #3 was asleep from 8:00 PM until the charting stopped at 2:45 AM on 11/18/14.</p> <p>The first nursing note for night shift (7:00 PM - 7:00 AM) on 11/17/14 was not entered until 11/18/14 at 12:56 AM. The narrative section noted Patient #3 was "resting comfortably in bed at this time." RN B noted Patient #3 took her medication crushed in pudding without hesitation, and went to sleep shortly after.</p> <p>The second and final nursing note for the night shift was entered on 11/18/14 at 3:23 AM. RN B wrote a narrative note that included many actions, however, the timing of events were not included. The resulting documentation lacked clarity as to the order of events, and interventions. There was no further documentation in Patient #3's record to more clearly detail the 7 hours from the first oxygen saturation of 77% until her transfer to the acute care hospital by ambulance at 3:09 AM. The narrative note is as follows:</p> <p>"Patient [#3's] pulse 128, [oxygen saturation] was 77% on room air. Applied oxygen via nasal cannula to 2 liters per minute. O2 [oxygen] came up to 82%. Patient non-responsive, staff were unable to wake patient. Switched oxygen to concentrator mask and O2 came up to 85%. Pulse 104, B/P 92/70. Patient still un-responsive.</p>	{A 144}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	<p>Continued From page 17</p> <p>Patient appeared to be struggling to breath. Accessory muscle being used to breath. Lung sounds with stridor throughout. Congestion audible in upper airway." The narrative continued with documentation the physician on call was notified and RN B was instructed to send Patient #3 to the ER for evaluation. RN B concluded the narrative with the arrival of paramedics at the facility and noted Patient #3 was transported on 11/18/14 at 3:00 AM.</p> <p>During a phone interview on 11/18/14 beginning at 3:00 PM, RN B confirmed she provided care for Patient #3 on the 11/17/14 night shift and provided further information about the events leading to her transfer. RN B stated she was notified around 7:00 PM, that Patient #3's oxygen saturation was 77%, and her heart rate was 128, when her vital signs were taken. RN B stated she was just about to get shift change report and requested the CNA retake the vitals.</p> <p>RN B stated when she finished getting report, she approached Patient #3 to ask her to wear her oxygen. She stated Patient #3 was in the dining room at that time, and she was compliant with the request. They placed her on oxygen by nasal cannula with a portable tank. RN B stated Patient #3 was difficult to understand, her eyes were half open, she appeared tired, and was slurring her words. RN B stated she told CNA G to notify her when Patient #3 went to bed, so she could complete her assessment.</p> <p>RN B stated Patient #3 was unsteady with her gait as she ambulated to her room, and was noted to refuse assistance from the staff.</p> <p>RN B stated at approximately 10:00 PM, CNA G,</p>	{A 144}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	<p>Continued From page 18</p> <p>who was assigned as a 1:1 with Patient #3, came up to the desk and alerted her that Patient #3 was having a difficult time breathing. RN B said she observed Patient #3 to be mouth breathing, and her lungs sounded "OK".</p> <p>RN B stated at approximately midnight, Patient #3 had upper airway congestion and she was unable to arouse her enough to cough. RN B stated Patient #3's heart rate was elevated in the 90's to 100's, and her oxygen saturations were in the 80's. She said Patient #3 was switched from nasal cannula to a mask.</p> <p>RN B stated around 1:00 AM, her co-worker LPN A contacted the SNF Patient #3 resided in prior to her transfer. She stated the facility provided LPN A with information about Patient #3's baseline vital signs and incidentally told her that Patient #3 experienced an unwitnessed fall that afternoon, approximately 20 minutes before her transfer. The information about the fall had not been passed from the SNF to Mountain View Center for Geriatric Psychiatry upon her transfer.</p> <p>RN B stated around 2:15 AM, Patient #3 was noted to have stridor (increased sounds during breathing indicating respiratory distress) and her oxygen saturations were in the low 80's. She stated she turned the oxygen flow up to 3 liters, her saturations went up to 85%, and then the on call physician was notified. At that time orders were received to transfer Patient #3 to the ED of an acute care hospital.</p> <p>During an interview on 11/18/14 beginning at 2:30 PM, CNA G, who was assigned as a 1:1 for Patient #3 during the night shift on 11/17/14, provided information regarding the events during</p>	{A 144}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  134014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 11/20/2014
NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY		STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341		
(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
{A 144}	<p>Continued From page 19</p> <p>her shift. CNA G stated at the beginning of her shift (7:00 PM), Patient #3 was in the dining room. She was yelling, and confused, asking to see her son and baby. CNA G stated RN B was notified of the vital signs around 7:00 PM. She said Patient #3 was falling asleep in her chair around 8:00 PM, so she went to bed. CNA G stated Patient #3 was not very responsive during that time, and was snoring.</p> <p>At approximately midnight, CNA G stated Patient #3's oxygen saturation levels were in the 70's and 80's, her blood pressure was 90/79, and she was switched from the nasal cannula to an oxygen mask. Additionally, she stated she tried to wake Patient #3 up, but she was "out of it". She stated RN B came in to the room every 1-2 hours. CNA G stated she kept the pulse oximeter on Patient #3 during the time she was in bed and provided RN B with the vital sign information, but did not write them down.</p> <p>During an interview on 11/18/14 beginning at 2:30 PM, CNA F, who was assigned to monitor Patient #3's behavior and 15 minute check documentation, described the events leading to Patient #3's transfer. CNA F stated that on 11/17/14 around 7:00 PM, Patient #3's pulse was high and her oxygen saturations were 85%. She stated she handed the paper with Patient #3's vitals to LPN A, and was told to repeat the vitals. CNA F stated she repeated the oxygen saturation measurement, and it was 81-85%. She stated RN B had Patient #3 started on oxygen by nasal cannula with a portable oxygen tank at 8:00 PM.</p> <p>CNA F stated she refilled the portable oxygen tank at 1:00 AM on 11/18/14, and when Patient #3 was changed to oxygen by mask, she was</p>	{A 144}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	<p>Continued From page 20</p> <p>switched over to an oxygen concentrator. CNA F stated RN B came in to assess Patient #3 around 2:00 AM. RN B listened to her breathing, Patient #3 was asleep, snoring, and wheezing. CNA F stated RN B then called the doctor for orders and the paramedics were called.</p> <p>A copy of the paramedic report, dated 11/18/14, indicated the call to transport was made at 2:39 AM. The paramedic team was dispatched at 2:41 AM, arrived at the facility at 2:45 AM, and was at Patient #3's bedside at 2:49 AM.</p> <p>The paramedic report indicated Patient #3 had an altered level of consciousness, abnormal vital signs, and difficulty breathing. The report noted Patient #3 was non-responsive and her only response to painful stimulus was to groan. Additionally, the paramedic report stated the nursing staff reported to them that Patient #3 had just started taking Thorazine. Information from the paramedic report is as follows:</p> <p>-At 2:50 AM, her heart rate was 96, respirations were 10, and oxygen saturation was 77%. She was switched from oxygen by face mask at 3 liters per minute to a non-rebreather mask at 15 liters per minute.</p> <p>- At 3:04 AM, her heart rate was 84, blood pressure 102/60, respirations were 10 and shallow.</p> <p>- At 3:05 AM, her heart rate was 84, oxygen saturations were 96%, and respirations were 10 and shallow. An IV was started at that time.</p> <p>- At 3:10 AM, her heart rate was 80, oxygen saturations were 96%, and respirations were 10</p>	{A 144}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  134014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 11/20/2014
NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY		STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341		
(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
{A 144}	<p>Continued From page 21 and shallow. She was enroute to the Emergency Room with the paramedic team.</p> <p>Patient #3 arrived at the ED on 11/18/14 at 3:17 AM.</p> <p>An H&amp;P, dictated by the ED Physician on 11/18/14 at 5:05 AM, noted Patient #3 presented to the ED with altered mental status and hypoxia. The physician noted Patient #3 had recently been started on Thorazine. At the time of her arrival, the physician noted Patient #3 was not arousable by painful stimuli, and had a low blood pressure of 88/55. She was admitted to the hospital at 6:20 AM the same day.</p> <p>Patient #3's admission H&amp;P, dictated by an NP at the acute care hospital on 11/18/14 at 6:03 AM, described Patient #3 as becoming increasingly somnolent, unarousable, and hypoxic after she received 2 doses of Thorazine the prior evening. Her assessment in the dictated H&amp;P stated "Altered mental status with hypoxia most likely related to introduction of high-dose Thorazine for patient's body weight along with several other sedating medications in her regimen".</p> <p>The admission H&amp;P dictated by a physician at the acute care hospital on 11/18/14 at 9:13 AM, noted the physician assessed Patient #3 collaboratively with the NP and was in agreement with her assessment. The physician noted Patient #3 was completely obtunded and responded to painful stimulus with garbled words. The assessment section of the dictated H&amp;P stated "Altered mental status, likely acute metabolic encephalopathy."</p> <p>The hospital failed to ensure Patient #3's</p>	{A 144}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}  A 145	<p>Continued From page 22</p> <p>admission medications were appropriate for use together and ordered in dosages consistent with her physical status. Additionally, the hospital failed to ensure Patient #3 was appropriately monitored and timely interventions initiated for medication over-sedation and potentially life-threatening side effects.</p> <p>482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT</p> <p>The patient has the right to be free from all forms of abuse or harassment.</p> <p>This STANDARD is not met as evidenced by: Based on review of patient records and staff interview, it was determined the hospital failed to ensure psychiatric treatment and interventions to treat depression were provided for 1 of 3 patients (Patient #1) residing in their facility during the survey. This resulted in potentially unnecessary mental anguish and neglect. Findings include:</p> <p>Patient #1 was a 76 year old male admitted to the facility on 10/03/14, with diagnoses of dementia with behavioral disturbance, and psychosis. He was admitted to the facility involuntarily at the direction of the state, pending legal proceedings.</p> <p>Patient #1's medication sheet included Wellbutrin (an antidepressant) 150 mg daily, ordered on 11/05/14. The dose was increased to 300 mg daily on 11/11/14. A progress note, written on 11/16/14, and signed by the psychiatric Medical Director, stated he discontinued the Wellbutrin because it was not helpful and may be causing loss of appetite.</p> <p>An Interdisciplinary Group (IDG) note, dated</p>	{A 144}  A 145		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 145	<p>Continued From page 23</p> <p>11/11/14, stated Patient #1 continued to report being depressed. A progress note, written on 11/16/14 and signed by an RN, included "[Psychiatric Medical Director] in on rounds. Tried to speak with pt, but pt would only shrug one shoulder or nod. [Psychiatric Medical Director] asked pt if he was feeling more upbeat and pt shook head no. Asked if he was still feeling sour and pt shook head yes."</p> <p>An Interdisciplinary Group (IDG) meeting was observed on 11/18/14 at 1:00 PM. The attendees included the psychiatric Medical Director, the medical physician, the psychiatric NP, the DON, the Director of Social Services, the dietician, the pharmacist and an RN.</p> <p>During the IDG meeting the psychiatric Medical Director stated he had prescribed Wellbutrin to treat Patient #1's depression. He stated he discontinued the Wellbutrin because it was causing decreased appetite and increased agitation. Additionally, the Medical Director told the group that he had a conversation with Patient #1, and told him that it would be in his best interest to not make passes at women in the future. The psychiatric Medical Director stated, "We could try other antidepressants but we're beyond that." He stated Patient #1 would be kept in a facility or in jail due to his legal situation.</p> <p>Patient #1's medical record did not include a care plan related to depression.</p> <p>During an interview on 11/20/14 at 11:00 AM, the Administrator stated he did not know Patient #1's depression was not being treated. He stated if he was aware he would have questioned the psychiatric Medical Director. Additionally he</p>	A 145		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
A 145  {A 385}	<p>Continued From page 24 stated, "That's not what we are about."</p> <p>Further efforts to treat Patient #1's depression were not pursued.</p> <p>482.23 NURSING SERVICES</p> <p>The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.</p> <p>This CONDITION is not met as evidenced by: Based on staff interview, review of patients' clinical records, facility policies, and observations, it was determined the hospital failed to ensure nursing services were organized to effectively meet the health care needs of psychiatric patients. This resulted in the failure of the facility to identify patients' initial and ongoing health care needs, ensure prompt notification of findings to the medical team, and provide safe and effective care. The findings include:</p> <ol style="list-style-type: none"> <li>1. Refer to A395 as it relates to the failure of the facility to ensure a registered nurse provided each patient with initial and ongoing evaluation of his/her health care needs and supervised the delivery of nursing services.</li> <li>2. Refer to A454 as it relates to the failure of the nursing staff to receive and transcribe physician orders accurately.</li> </ol> <p>This cumulative systemic failure to provide comprehensive and safe nursing assessment and ongoing care resulted in repeat Condition Level deficiencies and placed the health and safety of present and future patients at risk.</p>	A 145  {A 385}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 395}	<p>482.23(b)(3) RN SUPERVISION OF NURSING CARE</p> <p>A registered nurse must supervise and evaluate the nursing care for each patient.</p> <p>This STANDARD is not met as evidenced by: Based on observations, review of patient records and staff interview, it was determined the hospital failed to ensure nursing services provided complete and comprehensive assessments, timely interventions, and appropriate oversight of the care being provided to 1 of 3 (Patient #3) patients residing in the facility at the time of the survey. This resulted in delayed treatment of a patient experiencing an emergency medical condition requiring transport the ED of an acute care hospital. Findings include:</p> <p>Patient #3 was a 77 year old female admitted to the facility on 11/17/14, for psychiatric care related to acute manic phase of her bipolar disorder. Patient #3's 11/17/14 ADMISSION RECORD also included diagnoses of insomnia, hypothyroidism, chronic pain, macular degeneration, COPD, spinal stenosis, and osteoporosis. She came from an SNF where she resided from 11/12/14 to 11/17/14.</p> <p>The time of her admission was not documented. However, nursing notes from the SNF, dated 11/17/14, documented Patient #3 left the SNF at 4:15 PM and nursing staff at Mountain View Center for Geriatric Psychiatry began documentation of Patient #3's activity every 15 minutes at 4:45 PM. The hospital's Plan of Correction for deficiencies cited during the 10/06/14 follow-up survey included the use of "High Five" pre-printed standing order forms. The High Five referred to 5 high profile diagnoses</p>	{A 395}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  134014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 11/20/2014
NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY		STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341		
(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
{A 395}	<p>Continued From page 26 requiring special follow-up and special documentation.</p> <p>Patient #3's record included a High Five standing order form for use with patients who have a history of pneumonia, COPD exacerbation, or respiratory failure. It identified Patient #3 as having a history of pneumonia and/or respiratory failure. The form included specific standing orders to be followed. One of the orders stated the outside of Patient #3's medical record chart was to clearly identify that she had a high profile diagnosis which required special follow-up and documentation. However, during the survey her chart was not flagged with that information as per the standing order.</p> <p>During an interview on 11/19/14 beginning at 3:00 PM, the DON reviewed Patient #3's record and confirmed the standing orders were not implemented. She stated Patient #3 was identified as having one of 5 specific high profile diagnoses that required closer monitoring. The DON confirmed the outside of Patient #3's chart did not specifically identify her as having a high profile diagnosis.</p> <p>Patient #3's 11/17/14 admission orders written by the psychiatric NP, included the following scheduled medications:</p> <ul style="list-style-type: none"> <li>- Chlorpromazine (Thorazine), 50 mg, 4 times per day, scheduled 8:00 AM, 12:00 PM, 5:00 PM and 9:00 PM</li> <li>- Lithium, 300 mg, 2 times per day, scheduled 8:00 AM and 5:00 PM,</li> <li>- Clonazepam, 0.5 mg, 2 times per day, scheduled 8:00 AM and 5:00 PM</li> <li>- Nicotine Patch 14 mg, once daily, scheduled at</li> </ul>	{A 395}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 395}	<p>Continued From page 27</p> <p>5:00 PM</p> <ul style="list-style-type: none"> <li>- Synthroid, 75 mcg, once daily, scheduled at 6:00 AM</li> </ul> <p>Patient #3's admission orders also included the following PRN medications:</p> <ul style="list-style-type: none"> <li>- Ativan 1 mg, every 4 hours for anxiety</li> <li>- Tramadol 50 mg, up to 4 times daily for pain</li> <li>- Trazodone 50 mg, as needed at night for sleeplessness</li> <li>- Pro-Air, 2 puffs as needed for reactive airway disease</li> <li>- Flonase, 2 sprays each nostril as needed for runny nose</li> <li>- Calmoseptine cream, apply as needed for excoriation and redness</li> </ul> <p>Patient #3's hospital record included copies of her MAR from the SNF. The copies were faxed to the hospital from the SNF on 11/17/14 at 1:17 PM, prior to her arrival at the facility.</p> <p>The SNF MAR indicated 3 medications were introduced during her 5 day stay at the SNF:</p> <ul style="list-style-type: none"> <li>-Lithium (to treat bipolar disorder) 300 mg, 2 times per day was ordered on 11/14/17, the first dose given at 7:00 PM the same day.</li> <li>-Clonazepam (to treat anxiety) 0.5 mg, 2 times per day was ordered on 11/16/14, the first dose given at 8:00 PM the same day.</li> </ul> <p>Drugs.com, an on-line resource widely used by health care professionals for information on medications, was accessed on 11/21/14. It stated elderly patients should be observed closely as the drug may cause confusion and over-sedation in the elderly.</p>	{A 395}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 395}	<p>Continued From page 28</p> <p>-Thorazine (to treat psychotic behavior) 50 mg, 4 times per day, was ordered on 11/17/14, however, Patient #3 refused the first dose scheduled at 12:00 PM. Therefore, she had not taken Thorazine prior to her transfer and admission to Mountain View Center for Geriatric Psychiatry.</p> <p>The medications administered to Patient #3 on 11/17/14 at the SNF prior to her transfer included:</p> <ul style="list-style-type: none"> <li>- Lithium 300 mg, at 9:00 AM,</li> <li>- Clonazepam 0.5 mg, at 9:00 AM,</li> <li>- Tramadol 50 mg, at 8:00 AM for leg pain,</li> <li>- Ativan 1 mg, at 1:00 PM for anxiety.</li> </ul> <p>Patient #3's record included an "Admission Nursing Assessment," signed by RN C, the Admissions RN on 11/17/14 at 7:00 PM. The assessment noted Patient #3 was awake, alert, and intermittently confused, with increasing agitation.</p> <p>The narrative section of the Admission Nursing Assessment dated 11/17/14, and signed by RN C, included documentation of Patient #3's mental status. It included "Pt was cooperative [with] admission assessment initially, answered questions freely as the process cont [continued] pt became very non-compliant yelling 'stop leave me alone' hitting and striking out and pulling away from staff [with] more agitation. Several attempts made to cont [continue] assessment were refused and causes increased agitation. Will re-attempt at later time." The admission assessment included a section for vital signs, but all measurements other than an initial blood pressure, temperature, and respiratory rate were</p>	{A 395}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{A 395}	<p>Continued From page 29</p> <p>refused by Patient #3. Her pulse and oxygen saturation measurements were not performed. Her weight was identified as 104 pounds, her initial blood pressure was 106/80 and her respiratory rate was 18.</p> <p>A nursing note, dated 11/17/14 at 7:04 PM, was completed by RN D, the RN on duty for the day shift (7:00 AM to 7:00 PM). RN D noted Patient #3 was non re-directable, non-approachable, verbally aggressive, and confused.</p> <p>A form titled "15 Minute Mood and Behavior Observation Record," indicated Patient #3's behavior included physical aggression, verbal aggression, and delusions on 11/17/14 from 6:00 PM until 7:45 PM. Additionally, the form indicated she went to her room at 7:15 PM. The entries on the form were completed and initialed by CNA F.</p> <p>Patient #3's MAR documented medications scheduled to be given at 5:00 PM were:</p> <ul style="list-style-type: none"> <li>- Lithium 300 mg</li> <li>- Klonopin 0.5 mg</li> <li>- Thorazine 50 mg</li> <li>- Nicotine Patch, 14 mg</li> </ul> <p>Although Patient #3's MAR had the time of administration for the medications as 5:00 PM, the actual time the medications were administered was not noted. However, the medications were not administered before 5:35 PM. A surveyor observed LPN E administering medications to Patient #1 beginning at 5:25 PM on 11/17/14. Patient #1's medication pass took 10 minutes. LPN E stated she would be administering medications to Patient #3 after she completed Patient #1's medication pass,</p>	{A 395}			

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
--	---	--	--

NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

{A 395}	<p>Continued From page 30 therefore, the earliest they were administered was after 5:35 PM.</p> <p>Patient #3's MAR documented she received her 9:00 PM scheduled dose of Thorazine 50 mg, but during a phone interview on 11/18/14 beginning at 3:00 PM, RN B confirmed it was given between 8:00 and 8:30 PM. Additionally, RN B stated Patient #3 was awakened to take the Thorazine which she had crushed and mixed with pudding. Based on the time of administration of the medications scheduled at 5:00 PM, Patient #3 received 2 doses of Thorazine 50 mg possibly 2 hours and 25 minutes apart, but not more than 2 hours and 55 minutes apart. The medication was scheduled to be given 4 hours apart.</p> <p>Patient #3's High Five standing order form, referenced previously, also included the following orders:</p> <ul style="list-style-type: none"> <li>- Patient #3's medical physician was to be contacted immediately if the following was noted: Heart rate persistently greater than baseline, Oxygen saturation persistently below baseline, New or worsening shortness of breath, Respiratory rate persistently greater than baseline, Temperature persistently 1 or more degrees above baseline.</li> </ul> <p>The information below demonstrates that these standing orders were not followed. Patient #3's medical physician was not contacted immediately when her heart rate was elevated, she experienced worsening shortness of breath, and her oxygen saturation levels remained persistently below baseline for approximately 7 hours.</p>	{A 395}		
---------	--	---------	--	--

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  134014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 11/20/2014
NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY		STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341		
(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
{A 395}	<p>Continued From page 31</p> <p>The Doctor's Orders and Progress Notes form in Patient #3 record included a telephone order from the NP written on 11/17/14 at 3:30 PM. The note stated the orders were "to be reviewed upon admission." One order was "oxygen 2L/NC to maintain [oxygen] sats at or &gt; 88% (aspiration)."</p> <p>Patient #3's Physician Admission Orders form, completed and signed by RN C, (who was also the hospital Admissions RN), on 11/17/14 at 3:45 PM, included an oxygen protocol which stated "Oxygen per NC titrate to keep sats &gt; 90% or continuously [sic]." The line for M.D. signature and date was blank. The form also included "I, [name of psychiatrist] certify....I also certify that I have reviewed and approved the medical and behavioral care plans."</p> <p>Patient #3's record included a form titled "Weights and Vitals Summary." The form included vital signs as follows:</p> <p>11/17/14 at 7:15 PM, Oxygen saturation of 77% on room air. 11/17/14 at 9:30 PM, Oxygen saturation of 82% with oxygen via nasal cannula (flow rate was not documented). 11/18/14 at 12:12 AM, Oxygen saturation of 82% with oxygen via nasal cannula (flow rate was not documented). 11/18/14 at 1:05 AM, Oxygen saturation of 85% with oxygen via mask. 11/18/14 at 2:30 AM, Oxygen saturation of 80% with oxygen via mask.</p> <p>A blood pressure documented on the form as taken on 11/17/14 at 8:32 PM, was 106/80, and her temperature at the same time was 97.5.</p>	{A 395}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 395}	<p>Continued From page 32</p> <p>There were no further vital signs documented on the vital sign summary sheet.</p> <p>The Mayo clinic website, accessed on 11/26/14, stated a normal oxygen saturation level is 95-100%, and levels below 90% are considered low. Additionally it stated, "In order to function properly, your body needs a certain level of oxygen circulating in the blood to cells and tissues. When this level of oxygen falls below a certain amount, hypoxemia occurs..."</p> <p>Although Patient #3 demonstrated a low oxygen saturation level over several hours, her medical record did not include documentation of her respiratory rate, or an assessment of the quality of her respirations.</p> <p>Her blood pressure and temperature were documented at 8:32 PM, however a form titled "15 minute check, Alarm Check, and hour of sleep documentation," with entries by CNA F, indicated Patient #3 was asleep from 8:00 PM until the charting stopped at 2:45 AM on 11/18/14.</p> <p>The first nursing note for night shift (7:00 PM - 7:00 AM) on 11/17/14 was not entered until 11/18/14 at 12:56 AM. The narrative section noted Patient #3 was "resting comfortably in bed at this time." RN B noted Patient #3 took her medication crushed in pudding without hesitation, and went to sleep shortly after.</p> <p>The second and final nursing note for the night shift was entered on 11/18/14 at 3:23 AM. RN B wrote a narrative note that included many actions, however, the timing of events were not included. The resulting documentation lacked clarity as to the order of events, and interventions. There was</p>	{A 395}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST</b> <b>KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 395}	<p>Continued From page 33</p> <p>no further documentation in Patient #3's record to more clearly detail the 7 hours from the first oxygen saturation of 77% until her transfer to the acute care hospital by ambulance at 3:09 AM. The narrative note is as follows:</p> <p>"Patient [#3's] pulse 128, [oxygen saturation] was 77% on room air. Applied oxygen via nasal cannula to 2 liters per minute. O2 [oxygen] came up to 82%. Patient non-responsive, staff were unable to wake patient. Switched oxygen to concentrator mask and O2 came up to 85%. Pulse 104, B/P 92/70. Patient still un-responsive. Patient appeared to be struggling to breath. Accessory muscle being used to breath. Lung sounds with stridor throughout. Congestion audible in upper airway." The narrative continued with documentation the physician on call was notified and RN B was instructed to send Patient #3 to the ER for evaluation. RN B concluded the narrative with the arrival of paramedics at the facility and noted Patient #3 was transported on 11/18/14 at 3:00 AM.</p> <p>During a phone interview on 11/18/14 beginning at 3:00 PM, RN B confirmed she provided care for Patient #3 on the 11/17/14 night shift and provided further information about the events leading to her transfer. RN B stated she was notified around 7:00 PM, that Patient #3's oxygen saturation was 77%, and her heart rate was 128, when her vital signs were taken. RN B stated she was just about to get shift change report and requested the CNA retake the vitals.</p> <p>RN B stated when she finished getting report, she approached Patient #3 to ask her to wear her oxygen. She stated Patient #3 was in the dining room at that time, and she was compliant with the</p>	{A 395}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  134014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 11/20/2014
NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY		STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341		
(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
{A 395}	<p>Continued From page 34</p> <p>request. They placed her on oxygen by nasal cannula with a portable tank. RN B stated Patient #3 was difficult to understand, her eyes were half open, she appeared tired, and was slurring her words. RN B stated she told CNA G to notify her when Patient #3 went to bed, so she could complete her assessment.</p> <p>RN B stated Patient #3 was unsteady with her gait as she ambulated to her room, and was noted to refuse assistance from the staff.</p> <p>RN B stated at approximately 10:00 PM, CNA G, who was assigned as a 1:1 with Patient #3, came up to the desk and alerted her that Patient #3 was having a difficult time breathing. RN B said she observed Patient #3 to be mouth breathing, and her lungs sounded "OK".</p> <p>RN B stated at approximately midnight, Patient #3 had upper airway congestion and she was unable to arouse her enough to cough. RN B stated Patient #3's heart rate was elevated in the 90's to 100's, and her oxygen saturations were in the 80's. She said Patient #3 was switched from nasal cannula to a mask.</p> <p>RN B stated around 1:00 AM, her co-worker LPN A contacted the SNF Patient #3 resided in prior to her transfer. She stated the facility provided LPN A with information about Patient #3's baseline vital signs and incidentally told her that Patient #3 experienced an unwitnessed fall that afternoon, approximately 20 minutes before her transfer. The information about the fall had not been passed from the SNF to Mountain View Center for Geriatric Psychiatry upon her transfer.</p> <p>RN B stated around 2:15 AM, Patient #3 was</p>	{A 395}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{A 395}	<p>Continued From page 35</p> <p>noted to have stridor (increased sounds during breathing indicating respiratory distress) and her oxygen saturations were in the low 80's. She stated she turned the oxygen flow up to 3 liters, her saturations went up to 85%, and then the on call physician was notified. At that time orders were received to transfer Patient #3 to the ED of an acute care hospital.</p> <p>During an interview on 11/18/14 beginning at 2:30 PM, CNA G, who was assigned as a 1:1 for Patient #3 during the night shift on 11/17/14, provided information regarding the events during her shift. CNA G stated at the beginning of her shift (7:00 PM), Patient #3 was in the dining room. She was yelling, and confused, asking to see her son and baby. CNA G stated RN B was notified of the vital signs around 7:00 PM. She said Patient #3 was falling asleep in her chair around 8:00 PM, so she went to bed. CNA G stated Patient #3 was not very responsive during that time, and was snoring.</p> <p>At approximately midnight, CNA G stated Patient #3's oxygen saturation levels were in the 70's and 80's, her blood pressure was 90/79, and she was switched from the nasal cannula to an oxygen mask. Additionally, she stated she tried to wake Patient #3 up, but she was "out of it". She stated RN B came in to the room every 1-2 hours. CNA G stated she kept the pulse oximeter on Patient #3 during the time she was in bed and provided RN B with the vital sign information, but did not write them down.</p> <p>During an interview on 11/18/14 beginning at 2:30 PM, CNA F, who was assigned to monitor Patient #3's behavior and 15 minute check documentation, described the events leading to</p>	{A 395}			

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  134014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 11/20/2014
NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY			STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341		
(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	
{A 395}	<p>Continued From page 36</p> <p>Patient #3's transfer. CNA F stated that on 11/17/14 around 7:00 PM, Patient #3's pulse was high and her oxygen saturations were 85%. She stated she handed the paper with Patient #3's vitals to LPN A, and was told to repeat the vitals. CNA F stated she repeated the oxygen saturation measurement, and it was 81-85%. She stated RN B had Patient #3 started on oxygen by nasal cannula with a portable oxygen tank at 8:00 PM.</p> <p>CNA F stated she refilled the portable oxygen tank at 1:00 AM on 11/18/14, and when Patient #3 was changed to oxygen by mask, she was switched over to an oxygen concentrator. CNA F stated RN B came in to assess Patient #3 around 2:00 AM. RN B listened to her breathing, Patient #3 was asleep, snoring, and wheezing. CNA F stated RN B then called the doctor for orders and the paramedics were called.</p> <p>A copy of the paramedic report, dated 11/18/14, indicated the call to transport was made at 2:39 AM. The paramedic team was dispatched at 2:41 AM, arrived at the facility at 2:45 AM, and was at Patient #3's bedside at 2:49 AM.</p> <p>The paramedic report indicated Patient #3 had an altered level of consciousness, abnormal vital signs, and difficulty breathing. The report noted Patient #3 was non-responsive and her only response to painful stimulus was to groan. Additionally, the paramedic report stated the nursing staff reported to them that Patient #3 had just started taking Thorazine. Information from the paramedic report is as follows:</p> <p>-At 2:50 AM, her heart rate was 96, respirations were 10, and oxygen saturation was 77%. She was switched from oxygen by face mask at 3</p>	{A 395}			

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{A 395}	<p>Continued From page 37</p> <p>liters per minute to a non-rebreather mask at 15 liters per minute.</p> <p>- At 3:04 AM, her heart rate was 84, blood pressure 102/60, respirations were 10 and shallow.</p> <p>- At 3:05 AM, her heart rate was 84, oxygen saturations were 96%, and respirations were 10 and shallow. An IV was started at that time.</p> <p>- At 3:10 AM, her heart rate was 80, oxygen saturations were 96%, and respirations were 10 and shallow. She was enroute to the Emergency Room with the paramedic team.</p> <p>Patient #3 arrived at the ED on 11/18/14 at 3:17 AM.</p> <p>An H&amp;P, dictated by the ED Physician on 11/18/14 at 5:05 AM, noted Patient #3 presented to the ED with altered mental status and hypoxia. The physician noted Patient #3 had recently been started on Thorazine. At the time of her arrival, the physician noted Patient #3 was not arousable by painful stimuli, and had a low blood pressure of 88/55. She was admitted to the hospital at 6:20 AM the same day.</p> <p>Patient #3's admission H&amp;P, dictated by an NP at the acute care hospital on 11/18/14 at 6:03 AM, described Patient #3 as becoming increasingly somnolent, unarousable, and hypoxic after she received 2 doses of Thorazine the prior evening. Her assessment in the dictated H&amp;P stated "Altered mental status with hypoxia most likely related to introduction of high-dose Thorazine for patient's body weight along with several other sedating medications in her regimen".</p>	{A 395}			

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
--	---	--	--

NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 395}	Continued From page 38	{A 395}		
	<p>The admission H&amp;P dictated by a physician at the acute care hospital on 11/18/14 at 9:13 AM, noted the physician assessed Patient #3 collaboratively with the NP and was in agreement with her assessment. The physician noted Patient #3 was completely obtunded and responded to painful stimulus with garbled words. The assessment section of the dictated H&amp;P stated "Altered mental status, likely acute metabolic encephalopathy."</p> <p>The facility failed to ensure Patient #3 received comprehensive and appropriate nursing care and interventions necessary to protect her health and safety.</p>			
{A 454}	<p>482.24(c)(1) CONTENT OF RECORD: ORDERS DATED &amp; SIGNED</p> <p>All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.</p> <p>This STANDARD is not met as evidenced by: Based on review of patient records, facility policies, and staff interview, it was determined the facility failed to ensure all orders were dated, timed, and authenticated for 3 of 3 current patients (#1, #2, and #3) residing in the facility during the survey. This resulted in services administered to patients without a physician order, lack of authentication of physician orders, as well as, lack of clarity about the course of</p>	{A 454}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  134014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 11/20/2014
NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY			STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341		
(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	
{A 454}	<p>Continued From page 39 patient care. Findings include:</p> <p>The hospital's policy, titled "COUNTERSIGNATURE REQUIRED ON TELEPHONE/VERBAL ORDER", revision date "11/14", stated "All verbal orders will be transcribed by the licensed nurse....The telephone/verbal order will include the date, time, and signature of the person transcribing the order and the name of the clinician the order was obtained from. Telephone/erbal Orders shall be read back to the person giving or relaying the order by the person who records it on the record and noted as R&amp;V (repeated and verified). Telephone/verbal Orders which have been read back i.e. repeated and verified, are recorded as R&amp;V on the order sheet or in the electronic record." This policy was not followed. Examples include:</p> <p>1. Patient #1 was a 76 year old male admitted to the facility on 10/03/14, with diagnoses of dementia with behavioral disturbance, and psychosis.</p> <p>Patient #1's admission orders included an order for OT to evaluate and treat. They did not include an order for PT services.</p> <p>Patient #1's medical record included an OT evaluation and plan of care, completed and signed by the Occupational Therapist on 10/06/14. The plan of care was signed by the psychiatric Medical Director on 11/15/14. There was no documentation to indicate the Occupational Therapist had obtained a verbal order from a physician for the OT plan of care, however, OT services were documented weekly, beginning 10/06/14.</p>	{A 454}			

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 454}	<p>Continued From page 40</p> <p>Patient #1's medical record included a PT evaluation and plan of care, completed and signed by the Physical Therapist on 10/06/14. The plan of care was signed by the psychiatric Medical Director on 11/15/14. There was no documentation to indicate the Physical Therapist had obtained a verbal order from a physician for the PT evaluation or plan of care, however, PT services were documented 3 times a week, beginning 10/06/14.</p> <p>During an interview on 11/18/14 at 4:45 PM, the Administrator reviewed Patient #1's record and confirmed there was no documentation of verbal orders for the OT plan of care or for the PT evaluation and plan of care. Additionally, he confirmed the plans of care were not signed by the physician until 11/15/14. He stated the missing physician signature was noted during an audit by medical records and the physician signature was obtained on 11/15/14.</p> <p>PT and OT services were provided to Patient #1 without a physician's order.</p> <p>2. Patient #2 was a 61 year old male admitted to the facility on 9/11/14, for psychiatric care related to schizophrenia and acute psychosis with behavioral disturbances.</p> <p>Patient #2's record included an order written on 11/17/14 by the dietician, which stated "Discontinue 2 oz Ensure tid...V.O./[Physician's name]."</p> <p>During an interview on 11/18/14 beginning at 1:00 PM, the Dietician reviewed Patient #2's record and confirmed she wrote the order as a verbal</p>	{A 454}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST</b> <b>KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 454}	<p>Continued From page 41</p> <p>order. The Dietician stated that she wrote the order after reviewing Patient #3's record, diet history, and weight gain. The Dietician stated she did not speak with the physician before writing the order although she wrote "V.O." indicating a verbal order had been received.</p> <p>The facility failed to ensure all staff was trained to receive and transcribe physician orders.</p> <p>3. Patient #3 was a 77 year old female admitted to the facility on 11/17/14, for psychiatric care related to acute manic phase of her bipolar disorder.</p> <p>Patient #3's record included multiple examples of licensed staff writing orders that were not compliant with the inservices, training, and policy changes.</p> <p>a. A pre-printed form titled "Physician Admission Orders," dated 11/17/14, included a physician certification that Patient #3 required in-patient psychiatric care, and included orders such as therapy, lab work, bowel protocol, and diet. The form also stated Patient #3 was to have oxygen via nasal cannula continuously or as needed to keep saturations &gt;90%. Portions of the form were pre-printed, and portions of the form had a blank line to allow the writer to make the orders more patient specific, such as which lab work to draw, nectar-thick liquids, and what kind of therapy was needed. The form was filled out and signed on 11/17/14 at 3:45 PM, by RN C, who was also the Admissions RN for the facility. RN C signed in the section that identified her as "Nurse Verifying Orders." The section for the M.D. signature and date remained blank. The form did not identify how RN C obtained the information to</p>	{A 454}		

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

PRINTED: 01/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>11/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST</b> <b>KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 454}	<p>Continued From page 42</p> <p>complete the admission orders. There was no indication on the form that verbal or telephone orders were received from the physician before they were transcribed.</p> <p>During an interview on 11/18/14 beginning at 12:15 PM, the DON reviewed Patient #3's record and confirmed the order sheet did not include a physician signature, nor did it document how the admission nurse obtained the orders. The DON confirmed the orders were not in compliance with how the facility's POC detailed orders were to be written.</p> <p>b. A form titled "DOCTOR'S ORDERS AND PROGRESS NOTES," dated 11/18/14 at 2:20 AM, stated "Send to ER for evaluation of signs/symptoms of respiratory distress." This was followed by "TO repeated and verified" and was followed by RN B's signature. RN B did not include the name of the physician she received the order from.</p> <p>During an interview on 11/18/14 beginning at 12:15 PM, the DON reviewed Patient #3's record and confirmed that RN C did not include the name of the physician who ordered her transfer to the ED.</p> <p>The facility failed to ensure licensed staff received and transcribed orders correctly.</p>	{A 454}		