



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7012 1010 0002 0836 1963

December 26, 2013

Jerrilynn R. Herrera, Administrator
Bell Mountain Village & Care Center
706 South Main Street, PO Box 927
Hailey, ID 83333-0927

Provider #: 135069

Dear Ms. Herrera:

On **December 6, 2013**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Bell Mountain Village & Care Center by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date, to signify when you allege that each tag will be back in compliance.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. After each deficiency has been answered and dated, the administrator should sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in

the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **January 8, 2014**. Failure to submit an acceptable PoC by **January 8, 2014**, may result in the imposition of civil monetary penalties by **January 28, 2014**.

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

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

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

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

Jerrilynn R. Herrera, Administrator
December 26, 2013
Page 3 of 4

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **January 10, 2014 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **January 10, 2014**. A change in the seriousness of the deficiencies on **January 10, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 10, 2014** includes the following:

Denial of payment for new admissions effective **March 6, 2014**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 6, 2014**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS

Jerrilynn R. Herrera, Administrator
December 26, 2013
Page 4 of 4

Regional Office or the State Medicaid Agency beginning on **December 6, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **January 8, 2014**. If your request for informal dispute resolution is received after **January 8, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,



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

LKK/dmj
Enclosures

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

PRINTED: 12/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/06/2013
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NAME OF PROVIDER OR SUPPLIER BELL MOUNTAIN VILLAGE & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 706 SOUTH MAIN STREET HAILEY, ID 83333
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification and complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were: Sherri Case, BSW, LSW, QMRP, Team Coordinator Linda Kelly, RN</p> <p>The survey team entered the facility on December 2, 2013 and exited on December 6, 2013.</p> <p>Survey Definitions: BID = Twice a Day BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DON/DNS = Director of Nursing/Services LN = Licensed Nurse MAR = Medication Administration Record MG = Milligram MDS = Minimum Data Set assessment PO = By Mouth PRN = As Needed</p>	F 000		
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would</p>	F 225	<p>F225 Investigate/Report Allegations/Individuals</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #2: All future incidents will be investigated and communication with the POA will be performed by the Administrator or Designee, per family request.</p>	1/10/14

RECEIVED
JAN 23 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE
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 NHA 1/21/14

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

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F 225	<p>Continued From page 1</p> <p>indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of Resident Incident Reports, record review, and staff interview, it was determined the facility failed to ensure all injuries of unknown origin were thoroughly investigated. This was true for 1 of 5 sample residents (#2). Failure to investigate a "puncture/blood blister" on Resident #2's right heel could lead to harm from abuse. Findings include:</p>	F 225	<p>On 12/16/13, the resident's bed, wheelchair, bedroom, shower chair, and shower room were inspected for possible causes of injury to resident's heel. No sharp edges or other irregularities were noted. A skin assessment was performed by the DNS. No new injuries were noted.</p> <p>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>All residents have this potential to be affected. All future Accidents and Incidents will be investigated per policy and procedure.</p> <p>Measures to be put in place and/or systemic change to be made to ensure that the deficient practice does not recur:</p> <p>The Accidents and Incidents Policy and Procedure was reviewed and an inservice to nursing staff performed by the DNS on 12/13/13 with emphasis on skin assessment upon return to facility after outings, immediate reporting of all injuries to DNS and completion of investigative reports for use by the DNS for Incident Investigations.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>100% of incidents will be reported immediately to the DNS and Administrator. A full investigation will be performed on all Accidents and Injuries per Policy and Procedure.</p>	

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F 225	<p>Continued From page 2</p> <p>Resident #2 was admitted to the facility on 9/27/07 with multiple diagnoses, which included ankle/foot deformity, joint contracture, hypothyroidism, and generalized pain.</p> <p>The resident's annual MDS and most recent quarterly MDS assessments, dated 7/8/13 9/29/13 respectively, both coded, in part:</p> <ul style="list-style-type: none"> * Short and long-term memory problems; * Severely impaired cognition - never/rarely made decision; * Total dependence of 2 or more persons for bed mobility, toilet use, and bathing; * Total dependence of 1 person for personal hygiene; * Transfers occurred only once or twice with physical assist of 2 or more persons; * Locomotion on and off unit occurred only once or twice with physical assist of 1 person; * Dressing occurred only once or twice with physical assist of 2 or more persons; * Impaired range of motion in both upper and both lower extremities; and, * Wheelchair (w/c) use. <p>A Resident Incident Report (RIR), dated/timed as 7/24/13 at 5:30 a.m., included the following documentation, "CNA's were putting resident to bed and found a puncture/blood blister on residents R [right] heel then reported it to charge nurse. Resident had an outing on Sunday where this injury may have occurred d/t [due to] the type of injury and where it is at, the resident is mostly bed bound so it probably did not happen here. Some of the CNA's stated that they saw it yesterday but it was not reported. Small puncture in the center of a black blood blister located on residents [sic] R heel." Actions taken included</p>	F 225	<p>Beginning 1/7/14, the Administrator or designee will conduct Quality Assurance/Quality Improvement Audits to ensure skin assessments were completed on all residents returning from outings and appointments to ensure no injury occurred while out of the facility. The audit will include ensuring that an accident/injury report was filed immediately and a full investigation initiated. Staff/residents and/or family members will be included in the investigation, if indicated. The audits will be conducted weekly x 4 weeks, every 2 weeks x 4, and monthly x 3. The Administrator will report the results of the audits to the Quality Assurance Committee who will determine patterns and trends to guide further monitoring.</p> <p>Start date of the audit: 1/7/14</p> <p>End date of the Audit: 6/24/14</p>	

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F 225	<p>Continued From page 3</p> <p>family notification on 7/24/13 at 9:00 a.m.</p> <p>The Immediate Post-Incident Action regarding the 7/24/13 right heel "puncture/blood blister" included, "Resident had an outing with family on Sunday and now has a puncture/blood blister on R heel. Please report the injury as soon as you observe it to help narrow down the how and when it happened."</p> <p>Note: July 24, 2013 was a Wednesday. The Sunday before 7/24/13 was 7/21/13, which was 3 days before the "puncture/blood blister" was documented.</p> <p>The incident investigation included 10 Incident Accounts by 10 CNAs. Two CNAs who provided care for the resident on 7/18/13 did not observe the skin problem. A CNA who "Checked and changed resident before night shift rounds ended" on 7/21/13 did not observe the skin problem. A CNA who provided oral care and incontinence care on 7/22/13 did not observe the skin problem. A CNA who showered the resident after breakfast on 7/23/12 observed the skin problem and, "Reported to Nurses before."</p> <p>Another CNA who provided peri care and turned the resident on 7/23/13 at 11:00 a.m. observed the skin problem. Another CNA observed the skin problem while, "Changing resident at [2:00 p.m.] [date not indicated] I noticed the mark. I showed it to another CNA who said she got it on Sunday."</p> <p>One of the 3 remaining CNA Incident Accounts documented the skin problem was not observed and 2 of them did not indicate if the skin problem was or was not observed.</p> <p>Note: The incident investigation did not include any Incident Accounts by the family. And there was no documentation that an assessment of the</p>	F 225			

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F 225	<p>Continued From page 4</p> <p>resident's bed, w/c, any other equipment, the room, or the shower room, was included in the investigation.</p> <p>On 12/5/13 at about 12:30 p.m., the DNS was asked about the investigation regarding the puncture/blood blister on Resident #2's right heel. The DNS stated that when a change of ownership occurred on 10/1/13 the previous owner locked many documents, including incident investigations, in a room in the basement. She stated the documents were accessible by appointment only. When asked if the family was asked about the heel wound or if the equipment used for the resident was evaluated, the DNS stated she did not know and she would not know unless the previous DNS had documented it. The DNS added, "I think it was documented as facility acquired at some point just because we didn't know. We assumed it happened when she was out with [a family member]."</p> <p>On 12/5/13 at about 8:00 p.m., the Administrator was also informed of the issue. However, no other information or documentation regarding the issue was received from the facility.</p>	F 225		
F 248 SS=E	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 248	<p>F248 Activities Meet Interests/Needs of Each Resident</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #4: A written Activity Assessment was completed by the activity director on 1/7/14 to determine the resident's specific needs and preferences in regards to activities. Resident's care plan has been reviewed and updated to reflect resident's actual preferences.</p>	1/10/14

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F 248	<p>Continued From page 5</p> <p>Based on group, resident, family and staff interview, observations and record review the facility failed to provide an ongoing program of activities designed to meet the activity interests and needs for 1 of 7 sample residents (# 4) and 4 of 4 random residents actively participating in the group interview meeting. This failure placed the residents at risk for boredom, and decreased enjoyment in their daily routine with potential negative impact on their emotional well-being. Findings include:</p> <p>1. The December 2013 Activity Calendar documented activities ranged from 3 to 5 activities offered each day. Activities offered included council meetings, Beauty Shop and one to one meetings. Activities listed started between 9:00 and 11:00 a.m. in the morning and ended between 2:00 and 3:00 p.m. in the afternoon each day.</p> <p>On 12/3/13 at 10:00 a.m. the surveyors met with 4 residents of the facility. All of the residents were actively involved and responded when asked about the activities. Three of the residents responded there were not enough evening activities. One resident stated, "I've trained myself to not want to do anything. I go to bed right after dinner." All residents stated they would like more card games. The surveyor stated it was not on the calendar to play Bingo and 2 of the 3 resident's stated they would like to play Bingo. Four of 4 residents stated they would like to watch movies in the evening and have popcorn. One resident stated they "use to have someone who came to my room" to do exercise.</p> <p>On 12/4/13 at 3:00 p.m., the Activities Director (AD) stated that one of the resident's (who did not</p>	F 248	<p>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>All residents have this potential to be affected.</p> <p>Measures to be put in place and/or systemic change to be made to ensure that the deficient practice does not recur:</p> <ol style="list-style-type: none"> 1. Initial and Ongoing Activity Assessments will be reviewed and updated by 1/10/14 to ensure that activities are provided as identified in the assessments. Resident and family member input will be obtained at admission and at the quarterly care conferences to be included in the resident's activity plan of care. All new admissions will include an activity assessment with resident and family input and be renewed at a minimum of quarterly and with change of condition. 2. Activity schedule will discussed during each Resident Council Meeting to determine individualized preferences including specific games, such as BINGO. 3. Activity Calendar was updated on 1/1/14 to include activities that have been requested by the residents and to include evening activities. Evening activities will be scheduled at least 6 days per week beginning 1/1/14. There will be a scheduled activity at approximately 5:15, 3 times weekly and at 8 PM, 4 times weekly. Scheduled activities will include bingo, bowling, exercise class, crosswords, hoops, live music and tea time. The Activity Calendar will be updated each month to reflect voiced resident preferences. 		

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F 248	<p>Continued From page 6</p> <p>attend the meeting with the surveyors) did not like to be active during the day. The AD stated the CNAs would put a movie in for this resident about 9:00 p.m. once a week. The AD stated on Tuesday and Thursday's he came in at 9:00 a.m. and stayed until 4:30 or 5:00 to play games. When asked about the calendar, the AD stated there was no documentation of the activities after 3:00 p.m.</p> <p>On 12/3/13 at 5:50 p.m. direct care staff #1 stated occasionally the AD would play games with the residents between 4:00 p.m. and 5:00 p.m. Staff #1 stated they did not have movies very often, about 1 time per week. At 6:40 p.m. staff #2 stated there were "not a lot of activities" in the evening, and there was little going on after 5:00 p.m.</p> <p>2. Resident #4 was admitted to the facility on 11/4/09 and readmitted on 6/21/11 with diagnoses that included left intracranial injury (traumatic brain injury), contracture left leg, paralysis, and dementia with behavior disturbance.</p> <p>Resident #4's 6/21/11 Care Plan (CP) identified in the Problem/Need section a potential for social isolation related to impaired mobility. The Approaches section included to, "Provide in-room activities and supplies" for the resident. Another CP identified in the Problem/Need section, "Depression, Sexual Comments and agitation." The Approaches section included, "Resident enjoys brief times of soft music, golf or tennis on TV. Let him make the choice..."</p> <p>The resident's Department Notes included a note, dated 11/12/13, from Social Services which documented the MSW (Masters in Social Work)</p>	F 248	<p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Beginning 1/7/14, the Administrator or designee will conduct Quality Assurance/Quality Improvement Audits to ensure continued compliance. The audits will be conducted weekly x 4 weeks, every 2 weeks x 4, and monthly x 3. The Administrator will report the results of the audits to the Quality Assurance Committee who will determine further monitoring. The activity director will update the schedule calendar monthly to include activities per resident assessment findings.</p> <p>Start Date of the Audit: 1/7/14</p> <p>End date of the Audit: 6/24/14</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2013
NAME OF PROVIDER OR SUPPLIER BELL MOUNTAIN VILLAGE & CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 706 SOUTH MAIN STREET HAILEY, ID 83333		
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F 248	<p>Continued From page 7</p> <p>met with the resident and he stated, "TV is unsettling to him and that easy listening music he enjoys some." The MSW visited with the Social Services Designee to discuss trying to utilize more music with the resident.</p> <p>On 12/3/13 at 8:11 a.m. Resident #4 was observed in his room in a wheelchair. Neither the TV or radio were turned on. On 12/4/13 at noon the resident was laying in bed. Neither the TV or radio were turned on.</p> <p>On 12/3/13 at 2:00 p.m. the resident's family member stated Resident #4 was "bored out of his mind" and should be participating in more activities. The family member stated the resident previously had worked with wood and the resident might enjoy something to "sand."</p> <p>On 12/4/13 at 3:00 p.m., the AD stated he knew the resident liked country western music but was not aware the resident liked easy listening music.</p>	F 248		
F 280 SS=E	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,</p>	F 280	<p>F280 Right to Participate Planning Care – Revise CP</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #1, 2, 4, 5 and 6 Care Plans will be reviewed and updated to reflect actual care and current needs to include individualized identification of behaviors and/or signs and symptoms displayed by those specific residents.</p> <p>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action will be taken:</p>	1/10/14

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F 280	<p>Continued From page 8</p> <p>and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility did not ensure residents' care plans were revised/updated to reflect their current status and/or it could not be determined when interventions were implemented or discontinued. This was true for 5 of 7 sample residents (#s 1, 2, 4, 5 and 6). This created the potential for more than minimal harm if residents did not receive appropriate care because of lack of direction in their care plans. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 9/27/07 with multiple diagnoses, which included joint contractures.</p> <p>The resident's care plan included the problem, "Pressure ulcer to L [left] thumb," dated 11/16/12. Interventions included the undated entry, "Dietician to evaluate and follow up a least monthly."</p> <p>Wound Assessment Reports documented the left thumb pressure ulcer resolved on 10/8/13.</p> <p>On 12/4/13 at about 10:30 a.m., the DNS was asked if the monthly dietician follow up was still an active care plan intervention, the DNS stated,</p>	F 280	<p>All residents have the same potential to be affected. All care plans will be reviewed quarterly for accuracy.</p> <p>Measures to be put in place and/or systemic change to be made to ensure that the deficient practice does not recur:</p> <p>On admission, upon significant change in resident status, and as residents are due for their next MDS (Minimum Data Set) assessment resident care plan will be reviewed to ensure the care plan continues to accurately reflect the resident's status.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Monitoring of Corrective Action: Interdisciplinary team to include the DNS, Administrator, and MDS Coordinator will monitor all care plans weekly x 4, then monthly x 2 at the weekly Patient At Risk Meeting beginning January 7th, 2014. Ongoing audits will be determined by the MDS schedule and PRN resident change of condition.</p> <p>Start date of the audit: 1/7/14</p> <p>End date of the audit: 3/31/14</p>		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 280	<p>Continued From page 9</p> <p>"We need to d/c [discontinue] that pressure ulcer care plan." The DNS also acknowledged the intervention did not include an implementation date. She stated, "That [a date] would be helpful."</p> <p>On 12/5/13 at 12:30 p.m., the DNS and LN #3 accompanied the surveyor to the resident's room. When the nurses opened the resident's left fingers, a tiny intact darkened circular area, about 0.2 centimeters in diameter, near the center of the ball of the thumb was observed.</p> <p>No other information was received from the facility which resolved this issue.</p> <p>2. Resident #1 was admitted to the facility on 12/15/10 and readmitted on 2/1/12 with diagnoses that included Alzheimer's disease, dementia without behavior and depression.</p> <p>The resident's medical record included a Wound Assessment Report (WAR) dated 9/10/13 which documented a wound was identified to the right 5th toe on 8/29/13. The WAR documented in the Notes section that the right foot was to be elevated on a wedge when the resident was in a wheelchair.</p> <p>On 12/4/13 at 9:00 a.m. the resident was observed sitting in his wheelchair. A wedge cushion was observed on the pedals of his wheelchair.</p> <p>Resident #1's current Care Plan, dated 2/1/12, for Potential for Skin breakdown did not include the use of a wedge cushion in the Approach section.</p> <p>On 12/5/13 at 9:25 a.m. the DON stated the resident had a callous on his foot which was</p>	F 280		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 280	<p>Continued From page 10</p> <p>debrided by the physician. The DON stated the resident used the wedge as recommended.</p> <p>3. Resident #4 was admitted to the facility on 11/4/09 and readmitted on 6/21/11 with diagnoses that included left intracranial injury (traumatic brain injury), contracture left leg, paralysis, and dementia with behavior disturbance.</p> <p>a. During the morning meal observation on 12/3/13 at 8:55 a.m. the resident was served his meal on a small plate (approximately 5 inches in diameter). During the evening meal on 12/3/13 at 6:00 p.m. the resident was served small portions of sweet potato, pork and green beans on a saucer.</p> <p>The resident's 7/22/11 CP for Potential for weight gain included in the interventions to serve, "smaller portions each time to equal 1 complete serving." The CP did not clarify what a "smaller portion" was or to use a small plate with 3 small servings to serve each meal.</p> <p>The DON, on 12/5/13 at approximately 9:30 a.m., stated the physician and the family were concerned with Resident #4 gaining weight. At meals the resident would quickly eat all of his food and want 1 or 2 additional servings of the meal. The smaller plate was implemented to assist the resident to not eat too fast. The DON felt the care plan stating the resident was to receive smaller portions was sufficient.</p> <p>The Dietary Manager stated on 12/5/13 at 10:45 a.m. the food was served 1/3 at a time on a saucer as it was a "directive" from an RN.</p> <p>b. The resident's medical record included a CP</p>	F 280		

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

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F 280	<p>Continued From page 11</p> <p>with a line drawn through "Gastro Tube" and "stomach upset/function." The handwritten entries did not identify who wrote them. The Approaches included the following:</p> <p>"Prilosec prescribed for resident Maintain gastrostomy tube for medications Secure feeding tube to prevent dislodgement Check position of nasogastric tube prior to gravity flowing anything through tube..."</p> <p>The CP Approaches for gastro tube and stomach upset/function did not document when the interventions had been discontinued.</p> <p>On 12/3/13 at 5:50 p.m. CNA #1 stated the resident no longer had a gastrostomy tube.</p> <p>c. Resident #4's medical record included a CP dated 10/20/10 with a Problem/Need of, "joint contracture/pelvic torque." Approaches included to have the resident lie flat in bed without pillows under his head 2 times a day.</p> <p>The DON was informed on 12/5/13 at approximately 9:30 a.m. the resident was observed on 12/4/13 at noon with the head of his bed elevated. The DON stated the CP should have been discontinued.</p> <p>4. Resident #5 was admitted to the facility on 5/7/13 with diagnoses which included fracture, pain, dementia without behaviors and depressive disorder.</p> <p>The resident's 11/2013 recapitulation Physician Orders included an order for Ativan 0.5 mg at bedtime as needed for anxiety.</p> <p>The resident's 5/7/13 CP for Mental</p>	F 280			

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

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F 280	Continued From page 12 distress/Anxiety included Goals and Approaches; however, the CP did not identify the behaviors or signs or symptoms displayed by the resident. 5. Resident #6 was admitted to the facility on 11/20/09 with diagnoses which included Alzheimer's disease, dementia without behaviors and anxiety state. The resident's 11/2013 recapitulation Physician Orders included an order for Seroquel 50 mg every day for depression psychosis. The resident's 4/1/10 CP for Anxiety documented the resident was to receive Seroquel. The goal to have, "less calls and letter to her family regarding money being stolen" had a line drawn through it and "Resolved 1/23/13" was handwritten. Additionally, a line was drawn through "Show at least one sign that stress is being alleviated by next review." The DON stated on 12/6/13 at 10:55 a.m. the behaviors needed to be clarified. On 12/5/13 at 7:50 P.M. the Administrator, Vice President of Operations, DON and Medical Records Supervisor were informed of the above concerns. The facility provided no further information.	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309	F309 Provide Care/Services for Highest Well Being What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #4: The care plan was updated to include information regarding what services hospice will provide including the coordination between hospice and facility staff, resident, and family members on 12/10/13.	1/10/14	

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F 309	<p>Continued From page 13 and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, and record review, it was determined the facility failed to ensure: * A coordinated plan of care with hospice for Resident #4, placing the resident at risk for unmet needs; *A current order was in place prior to administering an antianxiety medication for Resident #4; *An elbow gel pad was used as identified in the care plan for Resident #4; and *Failed to complete a physician ordered laboratory test for Resident #2, placing the resident at risk for complications due to hypothyroidism. These deficient practices affected 2 of 5 sampled residents (#'s 2 & 4) and had the potential to cause more than minimal harm when residents did not receive treatment according to their clinical needs, or if aspects of their care and treatment were not adequately communicated with all entities involved in resident care. Findings included:</p> <p>1. Resident #4 was admitted to the facility on 11/4/09 and readmitted on 6/21/11 with diagnoses that included left intracranial injury (traumatic brain injury), contracture left leg, paralysis, and dementia with behavior disturbance.</p> <p>a. After the initial tour of the facility on 12/2/13 at 3:45 p.m. the DON stated Resident #4 received services from a hospice agency. The resident's 10/13 recapitulation Physician Orders included</p>	F 309	<p>Resident #4: The physician orders regarding Ativan have been clarified. Updated recapitulations have been placed in the resident's chart.</p> <p>Resident #4: The care plan for protective devices has been reviewed and updated to accurately reflect the resident's status.</p> <p>Resident #2: TSH lab was drawn on 12/31/13 and the results sent to the physician on 1/3/14.</p> <p>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>All residents with a hospice order have been identified and hospice care plans reviewed.</p> <p>All residents have the potential for medication errors. Medication error inservice was completed on 1/7/14.</p> <p>All residents with protective devices have been identified and the care plan reviewed to reflect current status.</p> <p>All residents with annual labs have been identified and are current.</p> <p>Measures to be put in place and/or systemic change to be made to ensure that the deficient practice does not recur:</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 14 "hospice to follow."</p> <p>Resident #4's most recent CP did not include information regarding what services the hospice service would provide. The resident had at least 14 areas of care to be provided with dates of the problem onset ranging from 4/1/11 to 9/25/13. All of the CP's stated on the top left "Hospice: NO." In the Role section of the CP, facility staff (CNA, Dietary staff etc.) were identified as responsible to implement the approaches. Hospice was not identified.</p> <p>The CP did not provide evidence of: *Integration to address coordination of care and communication between hospice and facility staff. *When (time and day of week) and what services hospice would provide and when and what services the facility would provide. *The care plan only described what the facility would do and did not describe what the hospice agency would do for the resident. *The care plan did not include if hospice was to be called for serious resident issues.</p> <p>The resident's clinical record provided evidence of hospice visits and entries made in the chart from 10/11/13 to 11/21/13. On 12/5/13 at 7:50 P.M. the Administrator, Vice President of Operations, DON and Medical Records Supervisor were asked for the co-coordinated plan of care and an agreement of services provided by the hospice agency for the resident. No further information was provided by the facility.</p> <p>Federal Guidance at F309 defines "... the hospice and nursing home must communicate, establish, and agree upon a coordinated plan of care for both providers which reflect the hospice philosophy, and is based on an assessment of</p>	F 309	<p>All new orders will be processed systematically per facility procedure. Nurses were inserviced on 1/7/14 covering the physician order processing procedure to ensure all steps are completed on every new order. Nurses were inserviced on 1/7/14 on the Labs Procedure including recurring the recurring lab orders process. All recurring labs orders such as TSH, PT/INR, CMP, (new and existing recurring orders) have been and will be entered into the computer MAR. A copy of the lab order will be given to the RHIT for review and to assure proper entry into the computer. In addition, the lab book will be checked by the night nurse and lab orders reported to the oncoming nurse daily. All existing recurring orders have been identified and reviewed and will alert in the computer MAR when due.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>The DNS and/or RHIT will monitor all new physician orders, including lab orders, on a daily basis x 2 weeks and weekly x 3 months starting 1/7/14.</p> <p>Start Date of the Audit: 1/7/13</p>		

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F 309	<p>Continued From page 15</p> <p>the individual needs and unique living situation in the facility ... This coordinated plan of care must identify the care and services which the SNF/NF and hospice will provide in order to be responsive to the unique needs of the patient/resident and his/her expressed desire for hospice care ... The facility's services are consistent with the plan of care developed in coordination with the hospice."</p> <p>NOTE: The National Hospice and Palliative Care Organization (NHPKO) define palliative care as, "treatment that enhances comfort and improves the quality of an individual's life during the last phase of life. No specific therapy is excluded from consideration. The test of palliative care lies in the agreement between the individual, physician(s), primary care giver, and the hospice team that the expected outcome is relief from distressing symptoms, the easing of pain, and/or the enhancing of quality of life."</p> <p>b. The resident's medical record included a "Note to Attending Physician/Prescriber" from the pharmacist requesting to discontinue the order for Ativan 1.0 mg twice a day. The physician's response, dated 9/27/13 was to, "D/C (discontinue) Ativan" and start Clonazepam 0.5 twice a day. The facility failed to clarify which order or if all orders for Ativan were to be discontinued.</p> <p>Resident #4's 10/13 Recapitulation Physician Orders included the following orders for Ativan: * 1.0 mg every 4 hours as needed for anxiety or jaw movement with a start date of 4/12/13 The resident's 10/13 Medication Administration Record (MAR) documented the order for 1.0 mg of Ativan was discontinued on 9/27/13. The MAR documented the resident received the medication on 10/15/13 and two times on 10/20/13.</p>	F 309		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 16</p> <p>* 2.0 mg every 4 hours as needed for anxiety or jaw movement with a start date of 4/12/13 and discontinue date of 10/27/13. The discontinue date on the MAR was 10/27/13 although the MAR was for 10/1/13 through 10/31/13. The MAR documented the resident received the medication on 10/3/13, 10/7/13, 10/11/13, 10/12/13, and 10/21/13.</p> <p>* 1.0 mg every 4 hours as needed for convulsions with a start date of 2/25/13 and discontinued on 9/27/13.</p> <p>NOTE: The 10/13 MAR documented the above medication was discontinued on 9/27/13 but the resident received the Ativan on 10/15/13, 10/18/13 and 10/19/13.</p> <p>The resident's medical record included a "Medication Error Analysis Tool" which documented in "Date Error Occurred" section, 10/2/13-10/24/13. The "Describe Error" section documented the Ativan was discontinued by the physician but missed by the nurses and the resident continued to receive Ativan.</p> <p>A Progress Note by the physician, printed 10/23/13, included "He is off of Ativan and we will continue Clonazepam 0.5 mg b.i.d. (twice daily)."</p> <p>On 12/5/13 at 11:45 a.m. the DON stated a medication error report was completed after Resident #4 received the medication after the physician had discontinued the medication.</p> <p>A fax dated 12/9/13 from the DON documented a medication error report was generated after the 10/23/13 Physician Progress Note was received by the facility. The fax stated that the facility had thought the physician order was to discontinue the scheduled Ativan not the as needed Ativan.</p> <p>The resident received Ativan at least 10 times in October after receiving the order to discontinue Ativan on 9/27/13.</p> <p>c. Resident #4's 11/4/09 Potential for Skin</p>	F 309		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 17</p> <p>Breakdown Care Plan (CP) included in the intervention section to use bilateral gel elbow pads (dated 2/18/13) when the resident was out of bed.</p> <p>The resident was not observed with the gel elbow pads on during observations in the dining room on 12/3/13 at 8:11 a.m. and on 12/4/13, at 9:05 a.m. During the observation on 12/4/13 LN #3 was asked about the gel elbow pads. LN #3 checked the resident and stated the resident was not wearing the elbow pads. At that time LN #3 left the dining room and returned with the gel elbow pads.</p> <p>2. Resident #2 was admitted to the facility on 9/27/07 with multiple diagnoses including hypothyroidism.</p> <p>The resident's recapitulation of Physician Orders for November 2013 included: * Levothyroxine (a thyroid hormone replacement medication) every day via gastrostomy tube - dated 2/6/13; and, * "Annual lab[oratory]: TSH [thyroid stimulating hormone test] (Nov[ember]" - dated 10/25/12.</p> <p>Review of the resident's clinical record revealed a TSH was done 11/8/12. However, a TSH for 2013 was not found.</p> <p>On 12/4/13 at 10:20 a.m., the DNS was asked about the resident's TSH for 2013. The DNS stated, "It may have been done and if it was we can get the lab results." The DNS asked the Medical Records Supervisor (MRS) to check on the lab report.</p> <p>At 10:25 a.m., in the presence of the DNS, the MRS stated, "We missed that lab."</p>	F 309		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/06/2013
NAME OF PROVIDER OR SUPPLIER BELL MOUNTAIN VILLAGE & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 706 SOUTH MAIN STREET HAILEY, ID 83333	
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F 309	Continued From page 18 The facility did not do an annual TSH for the resident as ordered by the physician. On 12/5/13 at about 8:00 p.m., the Administrator was also informed of the issue. No other information or documentation was received from the facility which resolved the issue.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of Resident Incident Reports (RIRs), and staff interviews, it was determined the facility failed to ensure residents were as free from accidents and hazards as possible. This was true for 2 of 5 sample residents (#s 3 and 5) and any independently mobile, cognitively impaired resident in the vicinity of the main bath storage closet. Failure to provide adequate supervision for Resident #3 resulted in forehead lacerations and skin tears and bruises. Failure to include recommended interventions to Resident #5's care plan for falls created the potential for more than minimal harm should the resident fall; and, failure to secure chemicals in the main bath storage closet created the potential for more than minimal	F 323	F323: Accidents/Chemical Storage What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #3: Plan of Care was reviewed and updated to include fall prevention interventions. Resident #5: Plan of Care was reviewed and updated to reflect current needs. Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. All care plans of current residents have been reviewed and updated. All new admissions will be assessed for fall risk and risk will be included in the plan of care. Plan of care will be reviewed and updated at a minimum of quarterly and with change of condition. 1. Falls Prevention Inservice was provided to staff on 1/7/14. 2. Lock on bathroom door was replaced on 12/9/13. Staff were inserviced on proper chemical storage on 12/30/13.	1/10/14

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F 323	<p>Continued From page 19</p> <p>harm should a resident(s) ingest unsecured chemicals or get shampoo in their eyes. Findings included:</p> <p>1. Resident #3 was admitted to the facility on 9/21/12 with multiple diagnoses which included Alzheimer's disease, dementia without behavior disturbances, psychosis, and personal history of fall.</p> <p>The resident's most recent quarterly and annual MDS assessments, dated 6/25/13 and 9/10/13 respectively, both coded, in part:</p> <ul style="list-style-type: none"> * Short and long-term memory problems; * Severely impaired cognition, never/rarely made decisions; * Extensive assistance of 2 or more people for bed mobility, transfers, toileting, and personal hygiene; * Limited range of motion in one upper extremity and both lower extremities; * Falls since admit/reentry/prior assessment: any falls - yes; and * Falls since admit/reentry/prior assessment: injury (not major) - one. <p>An RIR for Resident #3, dated 5/17/13 at 5:00 p.m., included the following documentation, "CNA [CNA's name] left resident on her bed to rest... [Same CNA's name] states that she checked resident at 5 PM, saw that the resident was about to fall, and left the room to retrieve a Hoyer [type of mechanical lift] Lift. When she returned to the room, the resident was on the floor partway under the bed...2 lacerations 1 cm [centimeter] long each to the L [left] forehead with scant amount of bleeding. 1 skin tear 1 cm square poorly approximated between the 3rd [sic] knuckles of the the 2nd and 3rd fingers of the R [right] hand</p>	F 323	<p>Measures to be put in place and/or systemic change to be made to ensure that the deficient practice does not recur:</p> <ol style="list-style-type: none"> 1. Annual Falls Prevention Inservice will be provided. 2. To ensure effective communication for temporary care plan items to reflect residents current condition, the inservice/information book at the front desk is updated to reflect current care plan/temporary care plan changes and is read and signed by staff every shift to ensure accurate communication. As needed, the DNS or charge nurse will update and "DC" any items that are no longer current. A copy of the temporary care plan will be placed in the chart. 3. All cabinets with chemicals in facility will be kept locked at all times to ensure resident safety. 4. Maintenance Supervisor will perform weekly rounds to ensure Central Bath cabinet doors and other cabinets containing chemicals are locked. Spa aides were inserviced on 12/30/14 with instructions to keep the Central Bath cabinet and other areas with chemicals locked at all times. <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Beginning 1/7/14, the Administrator or designee will conduct Quality Assurance/Quality Improvement Audits to ensure continued compliance. The audits will be conducted weekly x 4 weeks, every 2 weeks x 4, and monthly x 3. The Administrator will report the results of the audits to the Quality Assurance Committee who will determine further monitoring.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 20</p> <p>and one laceration with bruising 1 cm long between the 3rd knuckles of the 3rd and 4th fingers...Resident upset verbally. Wounds cleansed and Mepilex applied. An additional skin tear was found on res[ident's] L elbow 2x2cm [2 by 2 cm]." Immediate Post-Incident Action documented an individual and a group inservice was done.</p> <p>On 12/5/13 at 4:30 p.m., the DNS was asked about Resident #3's fall on 5/17/13. The DNS stated the resident fell when the CNA left the resident's room "to go get help." The DNS stated, "I was so mad."</p> <p>The facility failed to provide adequate supervision to prevent Resident #3 from falling off the bed.</p> <p>On 12/5/13 at about 8:00 p.m., the Administrator was informed of the issue. No other information or documentation was received from the facility regarding the issue.</p> <p>2. Resident #5 was admitted to the facility on 5/7/13 with diagnoses which included a fracture, pain, dementia without behaviors and depressive disorder.</p> <p>*An RIR dated 7/23/13 documented the resident received an abrasion on her right upper back, and right knee and a bruise on her right outer knee. The RIR narrative of the incident documented, "Resident was dressing herself. She was putting on her underwear balancing herself while holding on to the rocking chair when she slipped and fell..."</p> <p>A "Group Inservice" documented to remind the resident to sit on the bed when she was getting</p>	F 323	<p>Maintenance supervisor will check all locks weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>Start Date of the Audit: 1/7/13</p> <p>End date of the Audit: 6/24/14</p>		

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F 323	<p>Continued From page 21 dressed and to use her walker.</p> <p>*An RIR dated 8/10/13 documented the resident scraped her right knee and had 2 abrasions on her left inner knee, one of the abrasions was open. The RIR narrative of the incident documented the resident was in the dining room and, "...Her foot caught on the wheel of the walker and resident tumbled to the floor gracefully."</p> <p>A "Group Inservice" documented to assist the resident with, "transfers into chair in dining room. Provide time and space to allow resident to transfer safely."</p> <p>The resident's 5/7/13 care plan for Falls included in the Approach section to have an eye exam as necessary, keep glasses clean and encourage the resident to wear them, properly fitting non-skid shoes, instruct the resident on the use of the walker,...place items frequently used within easy reach and provide adequate lighting. The CP did not document any revisions had been done since the onset of the CP and specifically did not include the "Group Service" interventions documented on the RIR.</p> <p>3. On 12/3/13 at 1:45 p.m. the surveyor checked the door to the Central Bath (CB). The door was unlocked and a cabinet in the CB had a sign on it to keep the cabinet locked. The cabinet was unlocked and contained several personal grooming items and a container of Acid Disinfectant Cleaner. The cleaner had a warning on it the cleaner could cause eye damage. Additionally there was a bottle of Smooth and Cool Fresh Shampoo with a warning to contact the physician if eyes became irritated. The Vice</p>	F 323			

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

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F 323	Continued From page 22 President of Operations was shown the unlocked cabinet, noted the lock was broken and stated it needed to be repaired.	F 323			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure physician's orders included flow rates for the administration of oxygen (O2). This affected 1 of 5 (#1) residents sampled for oxygen therapy. This practice created the potential for harm for respiratory distress. Findings included: Resident #1 was admitted to the facility on 12/15/10 and readmitted on 2/1/12 with diagnoses that included Alzheimer's disease, Dementia without behavior and depression. Resident #1's 11/13 Physician Orders (recapitulation) included an order for O2 for air hunger with a start date of 10/24/13. The Physician's order did not include the rate of flow	F 328	F328 Treatment/Care for Special Needs What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #1: Physician's order has been clarified. Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action will be taken: Any resident with a physician's order for supplemental oxygen has the same potential. Measures to be put in place and/or systemic change to be made to ensure that the deficient practice does not recur: All existing recurring and PRN orders were reviewed and clarified to ensure a flow rate. DNS or Medical Records will monitor 100% of new PRN and recurring orders for supplemental oxygen to ensure that a flow rate is included. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:	1/10/14	

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F 328	Continued From page 23 for the O2. On 12/5/13 at 9:25 a.m. the DON stated the previous order for O2 had a flow rate but the current order for O2 as needed did not. On 12/5/13 at 7:50 P.M. the Administrator, Vice President of Operations, DON and Medical Records Supervisor were informed of the above concern. The facility provided no further information.	F 328	Beginning 1/7/14, the Administrator or designee will conduct Quality Assurance/Quality Improvement Audits to ensure continued compliance. The audits will be conducted weekly x 4 weeks, every 2 weeks x 4, and monthly x 3. The Administrator will report the results of the audits to the Quality Assurance Committee who will determine further monitoring. Start date of the audit: 1/7/14 End date of the audit: 6/24/14	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F329 Drugs/Labs What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Corrective Actions for the Residents Involved: 1. Resident # 4: Gradual Dose Reduction (GDR) was reviewed by the Interdisciplinary Team on 12/26/13 at the Psychotropic Committee Meeting (which included antidepressants). The Lexapro had been discontinued by the resident's physician on 12/10/13. Therefore, a GDR was unnecessary. 2. Resident #1, #5, #6: The resident's care plans were reviewed and updated on 1/7/14 to include specific individualized non-pharmalogical interventions. 3. Resident #3: The resident's TSH lab was completed on 1/2/14. Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action will be taken:	1/10/14

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F 329	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on staff interview, and record review, it was determined the facility failed to provide gradual dose reduction (GDR) for an antidepressant. This was true for 1 of 7 (#4) sample residents. The facility failed to monitor thyroid function for 1 of 2 sample residents on thyroid medication (#3). Additionally 3 of 7 sample resident's (1, 5 and 6) care plans failed to ensure nonpharmalogical interventions were used when the residents received antidepressants. This failed practice had the potential to cause harm to residents when they were given medications they may not have needed. Findings include: 1. Resident #4 was admitted to the facility on 11/4/09 and readmitted on 6/21/11 with diagnoses which included left intracranial injury (traumatic brain injury), contracture left leg, paralysis, and dementia with behavior disturbance. The resident's recapitulation 11/2013 Physician Orders included an order for Lexapro (antidepressant) 20 mg every morning with a start date of 2/25/13. His Medication Administration Record (MAR) documented the resident had received the antidepressant 12/1/13-12/3/13. Resident #4's medical record did not include documentation of an attempt to reduce the medication or physician rationale for not reducing the antidepressant dosage. 2. Resident #5 was admitted to the facility on 5/7/13 with diagnoses which included fracture,	F 329	All residents who have been prescribed a Psychotropic/Antidepressant medication have the same potential to be affected. Medical records of residents with a psychotropic/antidepressant medication order have been reviewed by the Psychotropic Committee. For residents meeting the criteria for a GDR, the Pharmacist has written a communication that has been sent to the physician outlining a recommendation by the Psychotropic Committee. Care plans of residents who are prescribed psychotropics have been updated to include non-pharmacological interventions. The nursing staff was inserviced on 1/7/14 regarding non-pharmalogical interventions for residents prescribed psychotropics. All residents with annual labs have the same potential to be affected. Lab orders have been completed to reflect current needs. Measures to be put in place and/or systemic change to be made to ensure that the deficient practice does not recur: 1. The care plans for all residents who have been prescribed Psychotropic/antidepressant medications will be reviewed quarterly to ensure that they contain nonpharmalogical interventions/approaches. 2. All new lab orders will be processed systematically. 3. Nurses have been inserviced on the "Physician Order Processing Procedure" and the Labs process to ensure all steps are completed on every new order. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:	

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F 329	<p>Continued From page 25</p> <p>pain, dementia without behaviors and depressive disorder.</p> <p>The resident's 11/2013 recapitulation Physician Orders included an order for Wellbutrin XL (antidepressant) 300 mg every morning with a start date of 5/7/13. The resident's MAR for 11/2013 documented she had received the antidepressant every day and her 12/2013 MAR documented she had received the medication 12/1- 12/3/13.</p> <p>The resident's 2/1/12 care plan (CP) with a Related Diagnosis of Depression included in the Approach section the resident was on Wellbutrin and to report/record any changes. The CP did not include nonpharmalogical interventions.</p> <p>On 12/5/13 at 9:45 a.m. the DON stated she would check for nonpharmalogical interventions. No further information was provided by the facility.</p> <p>3. Resident #1 was admitted to the facility on 12/15/10 and readmitted on 2/1/12 with diagnoses which included Alzheimer's disease, dementia without behavior and depression.</p> <p>The resident's 11/2013 recapitulation Physician Orders included an order for Celexa (antidepressant) 20 mg every day for depressive disorder with a start date of 2/7/12. The resident's 12/13 MAR documented the resident had received the medication on 12/1/13-12/3/13.</p> <p>The resident's 2/1/12 CP with a Related Diagnosis of Depression/insomnia included in the Approaches section to give the resident Celexa and to report/record any changes in mood or</p>	F 329	<ol style="list-style-type: none"> The DNS will participate as a member of the Monthly Psychotropic Committee Meeting. Recommendations will be sent to the physician to include GDR attempts with a request for either a GDR or rationale for not completing a GDR (such as previous failure of antidepressant GDR.) New recommendations regarding psychotropics/antidepressants will reviewed for accuracy and compliance before being sent to the physician for review. New orders will be reviewed by the DNS and implemented. Nonpharmalogical interventions for psychoactive medications will be documented at the end of every shift by the charge nurse and monitored by the DNS weekly x 4, then every 2 weeks x 4, and monthly x 3. All new lab orders will be processed according the "Physician Order Processing Procedure" and monitored by the RHIT for accuracy weekly x 4, then every 2 weeks x 4, and monthly x 3. <p>Start date of the Audit: 1/7/14</p> <p>End date of the Audit: 6/24/14</p>		

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F 329	<p>Continued From page 26</p> <p>behavior. The CP did not include any other interventions in the Approach section such as redirect, encourage participating in activities etc.</p> <p>The DON was informed of the above concern on 12/5/13 at approximately 9:15 a.m. and replied she would check for nonpharmalogical interventions. No further information was provided by the facility.</p> <p>4. Similar findings for Resident #6 related to nonpharmalogical interventions.</p> <p>On 12/5/13 at 7:50 P.M. the Administrator, Vice President of Operations, DON and Medical Records Supervisor were informed of the above concerns. The facility provided no further information.</p> <p>5. Resident #3 was admitted to the facility on 9/21/12 with multiple diagnoses including hypothyroidism.</p> <p>The resident's November 2013 recapitulation (recap) of Physician Orders and the November and December 2013 MARs included an order for levothyroxine (thyroid hormone replacement medication) 25 micrograms daily by mouth. The order was dated 9/21/12.</p> <p>The resident's 2 MARs contained documentation that levothyroxine was administered daily from 11/1 through 12/3/13.</p> <p>Review of the resident's clinical record revealed there were no laboratory studies which measured thyroid function (such as a TSH, or thyroid-stimulating hormone test) in the record. Note: The recap orders did not include an order</p>	F 329			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	Continued From page 27 for a TSH. On 12/5/13 at about 4:30 p.m., the DNS was asked if a TSH, or any other laboratory test, had been done to monitor the effectiveness of Resident #3's levothyroxine. The DNS reviewed the resident's record and confirmed there were no such tests in the record. The DNS said she would check on it and get back with the surveyor. On 12/5/13 at about 8:00 p.m., the Administrator and the DNS were informed of the issue. No other information/documentation was received from the facility which resolved the issue that the resident received levothyroxine for almost 15 months without any thyroid function monitoring.	F 329			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure food contact and non-food contact surfaces were free of debris and grime accumulation. This affected 5 of 6 sample	F 371	F371 Food Procure, Store/Prepare/Serve - Sanitary What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Corrective for Specific Residents Involved: Residents #1, 3, 4, 5, and 6 The main kitchen was thoroughly cleaned on 12/20/13. The cleaning included the Kitchen Aid Mixer, Hobart Toaster, Convection oven, gas stove backsplash, can openers, and workspace surfaces. Crazed coffee cups were replaced with new ones. Rusted potato peelers were discarded and replaced with new ones. Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action will be taken:	1/10/14	

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F 371	<p>Continued From page 28</p> <p>residents (#s 1, 3, 4, 5, and 6) and had the potential to affect all residents who dined in the facility. This failure created the potential for cross contamination of food and exposed residents to potential disease causing pathogens. Findings included:</p> <p>Note: The 2009 FDA Food Code, Chapter 4, Part 4-6, Cleaning of Equipment and Utensils, Subpart 601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils indicated, "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Non food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."</p> <p>On 12/2/13 from 2:35 p.m. to 3:05 p.m., during the initial tour of the main kitchen, with the Dietary Manager (DM) in attendance, the following was observed:</p> <ul style="list-style-type: none"> * There was an accumulation of bread crumbs, about 1/2 inch high in the middle, which covered more than half of both crumb trays in the 4-slice toaster. And, the pull surface on the bread crumb trays were covered with a light brown film that was sticky to the touch. The DM said the toaster was used that morning. She agreed, however, that the bread crumb build-up was excessive. Regarding the pull surface of the trays she stated, "They need to be cleaned." * The mixer frame had a dried off-white substance on the hook for the bowl and several spots of a similar substance on the handle lever. The DM acknowledged the substance on the mixer frame and she instructed a staff member to 	F 371	<p>All residents who receive food from the kitchen have the potential to be affected.</p> <p>Staff received an inservice on 12/31/13 regarding sanitation. Updated Checklists were provided for daily cleaning schedules.</p> <p>Measures to be put in place and/or systemic change to be made to ensure that the deficient practice does not recur:</p> <p>Daily, weekly, and monthly checklists will be completed by dietary staff on an ongoing basis supervised by the dietary manager.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>The dietary manager will monitor daily checklists daily for 1 week, weekly x 2, then monthly x 3. Administrator will randomly inspect the kitchen weekly x 4, q 2 weeks x 4, then monthly x 3.</p> <p>The dietary manager will submit completed daily checklists to the Administrator weekly x 3 months.</p> <p>Start date of the audits: 12/31/13</p> <p>End date of the Audit: 6/24/14</p>	

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

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F 371	<p>Continued From page 29</p> <p>clean it.</p> <p>* Approximately 90% of the inside of both convection oven glass doors were streaked with blackish, reddish, and brownish colored grimy substances, the door frame inside the oven itself was covered with similar substances, and the drip tray in the bottom of the oven was covered with a build-up of similar substances and several clumps, approximately 1/2 - 1 inch in size, of a charcoal like substance. The DM stated, "Yep, yep we need to clean it. It is right after the holidays, Thanksgiving."</p> <p>* There was a build-up of a black sticky substance on about 90% of the lower half of the backsplash on the gas stove. The DM acknowledged the build up on the backsplash and said, "It is a kitchen."</p> <p>* One of 2 hand held can openers in a drawer had a visible pale colored grime on both handles. The DM gave the grimy handled can opener to a staff member and instructed her to put in the warewashing machine.</p> <p>* There was rust on the blade surfaces on 2 of 3 potato peelers in a drawer. The DM tossed both of the rusty potato peelers in the trash.</p> <p>On 12/2/13 at about 3:25 p.m., during an initial tour of the small kitchen, or kitchenette, with the Administrator in attendance, 8 of 20 plastic single handled cups were observed with moderate to significant crazing inside them. The Administrator said the cups would be thrown out. She moved the 8 cups to a different tray with a note that the cups were not to be used.</p> <p>On 12/2/13 at 5:10 p.m., the Administrator, DNS, and Medical Records Supervisor were informed of the observations in the kitchen and kitchenette.</p>	F 371		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	Continued From page 30 On 12/4/13 at about 2:35 p.m., the convection oven and stove backsplash were observed in the same condition as noted on 12/2/13. The DM stated, "Because they are in use so much and hot. I have them scheduled for Sundays when they will be cooled down."	F 371			
F 431 SS=E	No other information was received from the facility which resolved the issues. 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431	F431 Drug Records, Label/Store Drugs and Biologicals What corrective action will be accomplished for those residents found to have been affected by the deficient practice: No specific residents were mentioned. Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action will be taken: All residents who receive Tubersol have the same potential to be affected. All residents who receive Narcotics from the e-kit have the same potential to be affected. An inservice was delivered on 1/7/14 regarding the proper procedure of writing an "opened" date on each medication with a "used by" date on the label. Measures to be put in place and/or systemic change to be made to ensure that the deficient practice does not recur: All medication including monthly cycle, PRN, Over the Counter, Narcotics, and E-kit Narcotics will be checked for expired date every month on the night shift using a flow sheet for accountability.	1/10/14	

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F 431	<p>Continued From page 31</p> <p>Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure an opened multidose bottle of Tubersol (used for TB (tuberculosis) skin testing) without an open date and expired fentanyl patches were not available for resident use; and, labels on syringes of oral morphine sulfate solution included an expiration date. This was true for 1 of 1 medication refrigerators and the narcotic Emergency Kit in 1 of 1 medication carts. This failure created the potential for reduced potency and inaccurate test results for any resident(s) who may have received the Tubersol; and, for decreased potency of the expired fentanyl patch or oral morphine solution which could result in inadequate pain control for any resident who received either of the pain medications. Findings included:</p> <p>On 12/5/13 at 3:55 p.m., during an inspection of the medication refrigerator in the medication room, with LN #4 in attendance, an opened, nearly 3/4's full, 5 milliliter (50 doses) bottle of Tubersol did not have an open date. LN #4 looked at the Tubersol bottle and the box it was in then agreed there was no open date on either. The LN also verified that instructions on the bottle's label said to discard it after it had been entered (opened) and in use for 30 days.</p>	F 431	<p>All medications including the E-kit box will be checked for expired medications by the pharmacist monthly using the Med Room Inspection Nursing Station Inspection Report and co-signed by the charge nurse.</p> <p>All medications with a "used by" date will have a written "opened" date written on the label.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>The DNS will monitor the monthly checklist on an ongoing basis.</p> <p>The DNS will randomly check for expired medications weekly x 4, q2weeks x 4, then monthly thereafter.</p> <p>Start date of the audit: 1/7/14</p> <p>End date of the Audit: 6/24/14</p>		

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F 431	Continued From page 32 On 12/5/13 at 4:15 p.m., during an inspection of the narcotic E-Kit in the medication cart, with LN #4 in attendance, the following was found: * Eight of 8 syringes labeled as morphine sulfate (fast acting opioid pain medication) solution 20 milligrams (mg)/milliliter (ml) with 5 mg, or 0.25 ml, in each syringe for oral administration did not have an expiration date; and, * Two of 2 fentanyl (long-acting pain opioid medication) expired in October 2013. LN #4 stated she would dispose of the Tubersol and that she would dispose of the fentanyl patches and morphine solution when another nurse was available to witness it. On 12/5/13 at about 8:00 p.m., the Administrator, DNS, Vice President of Operations, and Medical Records Supervisor were informed of the observations. No other information/documentation was received from the facility which resolved the issues.	F 431			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State;	F 514	F514 Resident Records-Complete/Accurate/Accessible What corrective action will be accomplished for those residents found to have been affected by the deficient practice:	1/10/14	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	<p>Continued From page 33 and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a recapitulation of physician orders was accurate, a neurological check document included dates, and a care plan included the correct side effects for an antipsychotic medication. This was true for 3 of 5 sample residents (#s 2, 3, and 6). The failure created the potential for more than minimal harm should Resident #2 be fed a diet that should have been discontinued and/or staff failed to recognize the side effects of the antipsychotic medication Seroquel. Findings included:</p> <p>1. Resident #2's November 2013 Physician Orders recapitulation (recap) included: * Jevity tube feeding 3 times a day from 7:00 to 9:00 a.m., 12:00 p.m. to 2:00 p.m., and 5 p.m. to 7:00 p.m., dated 2/6/13; and, * Pureed diet with nectar thickened liquids, dated 3/9/11.</p> <p>The resident's care plan identified the problem, "Altered oral intake r/t [related to] dysphagia and emesis." Approaches included, "All caloric needs are med [sic] via G [gastrostomy tube]-tube..."</p> <p>Throughout the survey, the resident was always observed in bed. The tube feeding was observed in place and running on 12/3/13 at 12:50 p.m. and 2:00 p.m., 12/4/12 at 12:20 p.m., and 12/5/12 at 12:30 p.m. A diet tray was never observed in the resident's room.</p> <p>On 12/4/13 at 10:20 a.m., the DNS was asked</p>	F 514	<p>Resident #2: The care plan was reviewed and revised to reflect the resident's current status on 12/30/13.</p> <p>Resident #3: A medical records correction was completed by the RHIT on 12/30/13.</p> <p>Resident #6: The care plan was reviewed and revised by placing the correct "anti-psychotic sticker" in the care plan to replace the incorrect "anti-depressive sticker" on 12/30/13.</p> <p>Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>All residents have the same potential for medical records errors.</p> <p>Measures to be put in place and/or systemic change to be made to ensure that the deficient practice does not recur:</p> <p>Monthly chart audits based on MDS Quarterly Schedule will be completed to include care plans and physician recapitulations to ensure that the medical record is complete, accurate, and reflects residents current status.</p> <p>Nurses were inserviced on 1/7/14 regarding the 24 hour chart check to ensure all new orders are accurately reflected in the medical record.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p>	

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F 514	<p>Continued From page 34</p> <p>about the diet order on the resident's recap orders. The DNS stated, "That needs to be taken out. She's been NPO [nothing by mouth] for a very long time."</p> <p>2. Documentation of a Resident Incident Report (RIR), dated 6/29/13 at 4:15 a.m., for Resident #3 included the resident was found on the floor next to her bed with a "bump/reddened area" on the right forehead and on the left cheek and a skin tear to the nose, among other minor injuries.</p> <p>On 12/5/13 at 4:30 p.m., the DNS was asked if neurological (neuro) checks had been done regarding the resident's 6/29/13 fall with facial/head injuries. She said she would check.</p> <p>At about 6:15 p.m., the DNS provided an undated Neurological Evaluation Flow Sheet which she said was done related to the resident's 6/29/13 unwitnessed fall. The DNS acknowledged that the flow sheet did not contain any dates.</p> <p>On 12/5/13 at about 8:00 p.m., the Administrator was also informed of the issue. No other information was received from the facility which resolved the issue.</p> <p>3. Resident #6 was admitted to the facility on 11/20/09 with diagnoses which included Alzheimer's disease, dementia without behaviors and anxiety state.</p> <p>The resident's Care Plan for Anxiety and mental distress documented the resident was to receive Seroquel (antipsychotic). The care plan had a non-removable preprinted sticker on it which documented the side effects of an</p>	F 514	<p>Beginning 1/7/14, the Administrator or designee will conduct Quality Assurance/Quality Improvement Audits to ensure continued compliance. The audits will be conducted weekly x 4 weeks, every 2 weeks x 4, and monthly x 3.</p> <p>Start Date of the audit: 1/7/14</p> <p>End date of the Audit: 6/24/14</p>	

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F 514	Continued From page 35 antidepressant. The sticker had a line on it for the facility to handwrite the name of the anti-depressant, however the facility had handwritten Seroquel (antipsychotic) on the line. On 12/5/13 at about 8:00 p.m., the Administrator was informed of the issue. No other information was received from the facility which resolved the issue.	F 514			

Bureau of Facility Standards

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual State licensure and complaint investigation survey of your facility. The surveyors conducting the survey were: Sherri Case, BSW, LSW, QMRP, Team Coordinator Linda Kelly, RN The survey team entered the facility on December 2, 2013 and exited on December 6, 2013.	C 000		
C 175	02.100,12,f Immediate Investigation of Incident/Injury f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Refer to F 225 as it related to investigation of all injuries of unknown origin.	C 175	Refer to F225	1/10/14
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules	C 325	Refer to F371	1/10/14

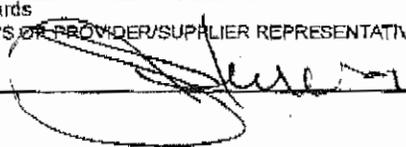
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JAN 23 2014
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NHA	(X6) DATE 1/21/14
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Bureau of Facility Standards

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual State licensure and complaint investigation survey of your facility. The surveyors conducting the survey were: Sherri Case, BSW, LSW, QMRP, Team Coordinator Linda Kelly, RN The survey team entered the facility on December 2, 2013 and exited on December 6, 2013.	C 000	RETAINED AS PROOF OF DATE OF RECEIPT RECEIVED JAN 07 2014 FACILITY STANDARDS	
C 175	02.100,12,f Immediate Investigation of Incident/Injury f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Refer to F 225 as it related to investigation of all injuries of unknown origin.	C 175	Refer to F225	1/10/14
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules	C 325	Refer to F371	1/10/14

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE
NHA

(X8) DATE

1-7-14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001050	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/06/2013
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BELL MOUNTAIN VILLAGE & CARE CENTER

**706 SOUTH MAIN STREET
HAILEY, ID 83333**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 325	Continued From page 1 Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Refer to F371 as it related to unsanitary conditions in the kitchen.	C 325		
C 342	02.108,04,b,ii Toxics Stored Under Lock and Key ii. All toxic chemicals shall be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Refer to F 323 as it related to the storage of chemicals.	C 342	Refer to F323	1/10/14
C 674	02.151,01 ACTIVITIES PROGRAM 151. ACTIVITIES PROGRAM. 01. Organized Program. There shall be an organized and supervised activity program appropriate to the needs and interests of each patient/resident. The program shall be designed to include a variety of processes and services which are designed to stimulate patients/residents to greater self-sufficiency, resumption of normal activities and maintenance of an optimal level of psychosocial functioning. It shall include recreation, therapeutic, leisure and religious activities. This Rule is not met as evidenced by: Please refer to F248 as it relates to activities.	C 674	Refer to F248	1/10/14
C 747	02.200,01,e Individualized Resident Care Plan	C 747	Refer to F280	1/10/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001050	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/06/2013
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NAME OF PROVIDER OR SUPPLIER BELL MOUNTAIN VILLAGE & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 706 SOUTH MAIN STREET HAILEY, ID 83333
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C 747	Continued From page 2 e. Observing and evaluating the condition of each patient/resident and developing a written, individualized patient care plan which shall be based upon an assessment of the needs of each patient/resident, and which shall be kept current through review and revision; This Rule is not met as evidenced by: Refer to F 280 as it related to care plan revisions.	C 747		
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Please refer to F309 and F328.	C 788	Refer to F309 and F328	1/10/14
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F 323 as it related to accidents and injuries.	C 790	Refer to F323	1/10/14
C 821	02.201,01,b Removal of Expired Meds b. Reviewing all medications in the facility for expiration dates and shall be responsible for the removal of discontinued or expired drugs from use as indicated at least every ninety (90) days.	C 821	Refer to F431	1/10/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001050	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/06/2013
NAME OF PROVIDER OR SUPPLIER BELL MOUNTAIN VILLAGE & CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 706 SOUTH MAIN STREET HAILEY, ID 83333		
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C 821	Continued From page 3 This Rule is not met as evidenced by: Refer to F 431 as it related to expired medications and medications without an expiration date.	C 821		
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Refer to F 514 as it related to dated and accurate resident medical records.	C 881	Refer to F514	1/10/14
C 882	02.203,02,a Resident Identification Requirements a. Patient's/resident's name and date of admission; previous address; home telephone; sex; date of birth; place of birth; racial group; marital status; religious preference; usual occupation; Social Security number; branch and dates of military service (if applicable); name, address and telephone number of nearest relative or responsible person or agency; place admitted from; attending physician; date and time of admission; and date and time of discharge. Final diagnosis or cause of death (when applicable), condition on discharge, and disposition, signed by the attending physician, shall be part of the medical record.	C 882	C882 Resident Identification Requirements What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #8: The Record of Death was reviewed by the RHIT and sent to the physician for a revision. Identification of other residents having the same potential to be affected by the same deficient practice and what corrective action will be taken:	1/10/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001050	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/06/2013	
NAME OF PROVIDER OR SUPPLIER BELL MOUNTAIN VILLAGE & CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 706 SOUTH MAIN STREET HAILEY, ID 83333		
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C 882	<p>Continued From page 4</p> <p>This Rule is not met as evidenced by: Based on record review and staff interview it was determined that a cause of death was not documented for one of one resident whose closed record was reviewed (#8). Findings include:</p> <p>Resident #8 was admitted to the facility on 9/24/13 and died in the facility on 10/5/13.</p> <p>On 12/5/13 at 11:15 a.m., the resident's closed medical record was reviewed with the Medical Records Supervisor's (MRS) assistance. This review revealed that a cause of death, or final diagnosis, was not included in the resident's closed medical record. When asked about the final diagnosis, the MRS pointed to the bottom section of the resident's Face Sheet and stated, "The doctor just wrote death. That's all. She's new."</p> <p>On 12/5/13 at about 8:00 p.m., the Administrator and DNS were informed of the issue. No other information was received from the facility which resolved the issue.</p>	C 882	<p>All residents have the potential to be affected.</p> <p>Measures to be put in place and/or systemic change to be made to ensure that the deficient practice does not recur:</p> <p>100% of future Record of Death Forms will be reviewed by RHIT for accuracy to include a final diagnosis.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>100% of all Record of Death Forms will be reviewed by RHIT and the DNS monthly x 3 months.</p> <p>Start Date of the Audit: 1/7/14</p> <p>End date of the Audit: 4/7/14</p>	



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

February 26, 2014

Jerrilynn R. Herrera, Administrator
Bell Mountain Village & Care Center
706 South Main Street
Hailey, ID 83333-0927

Provider #: 135069

Dear Ms. Herrera:

On **December 6, 2013**, a Complaint Investigation survey was conducted at Bell Mountain Village & Care Center. Linda Kelly, R.N. and Sherri Case, L.S.W., Q.M.R.P. conducted the complaint investigation. This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey.

The records of ten residents, which included the identified resident's record, were reviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006286

ALLEGATION #1:

The complainant stated that an identified resident, who said he was hungry because he slept through dinner, was not allowed to get out of bed and eat.

FINDINGS:

Grievances for the six months prior to the survey were reviewed. None of the grievances identified that residents were not allowed to eat if they missed a meal.

At a group meeting that the surveyors had with the residents, the residents stated they were allowed to go to bed or get out of bed when they wanted. There was no set times that they had to be in bed or get out of bed. Three of four residents at the meeting stated if they were hungry at night, they could get something

Jerrilynn R. Herrera, Administrator
February 26, 2014
Page 2 of 2

to eat.

Family members were interviewed and stated that the residents were served enough to eat. The identified resident's family member stated the resident had gained weight while at the facility.

An investigation that the facility had conducted related to this issue documented the licensed nurse (LN) instructed the certified nurse aides (CNAs) to elevate the head of the resident's bed and have him eat soup in bed. Instead, the CNAs used the Hoyer lift to get the resident out of bed. Shortly thereafter, the Director of Nursing came to the facility and observed that the resident was in the television room in his wheelchair with a cup of soup and some pudding.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated a nurse gave a resident more medication than was prescribed by the physician.

FINDINGS:

Based on records reviewed and staff interviews, it was determined the facility failed to ensure there was an active physician's order for an antianxiety medication that was given to the identified resident. The facility was cited at F309.

CONCLUSIONS:

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

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

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

Sincerely,



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

LKK/dmj