



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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3232 Elder Street
P.O. Box 83720
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May 25, 2016

Rob Deloach, Administrator
Bell Mountain Village & Care Center
620 N 6th St
Bellevue, ID 83313-5174

Provider #: 135069

Dear Mr. Deloach:

On **May 13, 2016**, a survey was conducted at Bell Mountain Village & Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern 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. If applicable, a similar State Form will be provided 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." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) 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.

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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 6, 2016**. Failure to submit an acceptable PoC by **June 6, 2016**, may result in the imposition of penalties by **June 30, 2016**.

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

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

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

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

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 **August 11, 2016 (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 **August 11, 2016**. A change in the seriousness of the deficiencies on **June 27, 2016**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **August 11, 2016** includes the following:

Denial of payment for new admissions effective **August 11, 2016**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, 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 **November 9, 2016**, 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, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **August 11, 2016** 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 non-compliance 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>

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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 **June 6, 2016**. If your request for informal dispute resolution is received after **June 6, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in black ink that reads "Nina Sanderson for". The signature is written in a cursive style.

Nina Sanderson, Supervisor
Long Term Care

NS/pmt
Enclosures

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

PRINTED: 06/29/2016
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 05/13/2016
NAME OF PROVIDER OR SUPPLIER BELL MOUNTAIN VILLAGE & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 620 NORTH SIXTH STREET BELLEVUE, ID 83313		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey from May 9 to May 13, 2016. The surveyors conducting the survey were: Presie C. Billington RN, Team Coordinator David Scott RN Jenny Walker RN Definitions include: ADM - Administrator ADON - Assistant Director of Nursing BID - Twice a day BPH - Benign Prostate Hypertrophy cc - cubic centimeters CNA - Certified Nursing Assistant FSS - Food Service Supervisor HS - At Bedtime kg - kilogram lbs - pounds LN - Licensed Nurse MAR - Medication Administration Record mg - milligram ml - milliliter MDS - Minimum Data Set PRN - As Needed PROM - Passive Range of Motion PO - By Mouth QOD - Every Other Day RNA - Restorative Nursing Assistant	F 000			
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and	F 156		5/13/16	

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

TITLE

(X6) DATE

Electronically Signed

06/06/2016

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 156	<p>Continued From page 1</p> <p>responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including</p>	F 156			

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F 156	<p>Continued From page 2</p> <p>the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p>	F 156			

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F 156	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure information and contact numbers for Medicare, Medicaid, and resident advocacy groups was posted. This was true for 9 of 9 (#s 1-9) sampled residents and all residents residing in the facility who may want to contact the agencies. Findings include: On 5/10/16 at 8:12 am, it was observed the Medicare and Medicaid, and resident advocacy groups information and contact numbers were not found on the bulletin boards in both the Galena and Hemingway building or anywhere in the facility. On 5/10/16 at 2:00 pm, the ADON acknowledged the Medicare and Medicaid, and resident advocacy group's information and contact numbers was not posted on the bulletin board in both buildings.	F 156	F156 Medicaid/Care Contact information Posted Medicare and Medicaid benefits information registration and contact information, as well as State and Federal advocacy information was reposted May 11, 2016. This deficiency has the potential to affect all the residents in the facility. We will monitor compliance by adding a bulletin board check to weekly focused rounds, for each building. The administrator or designee will monitor weekly for compliance and will document in the focused round log book. During IDT, the results of focused rounds will be shared with the team and documented. This will assure focused attention on the proper contact information being included on the communal bulletin board.		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this	F 164		6/6/16	

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F 164	<p>Continued From page 4 section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure personal privacy for 1 of 1 (#11) randomly observed resident. This resulted in a lack of privacy during personal care, which had the potential to negatively impact Resident #11's psychosocial well being. Findings include: On 5/11/16 at 9:35 am, Resident #11's window blind was observed in the up position and her door was open while LN #2 was providing nursing care to her. The gazebo could be seen from the window. Resident #11 was lying in bed with a sheet covering her body from her waist down and her legs were bent. LN #2 removed the Resident #11's soiled pull ups and cleaned her private parts using sanitary wipes. LN #2 put clean pull ups on Resident #11 afterwards. This was done while the Resident # 11 was covered</p>	F 164	<p>F 164 Personal Privacy/Confidentiality of Records This deficiency has the potential to affect each resident at Bell Mountain Care Center. In addition to adversely affecting privacy, residents' dignity could also be adversely affected. To this end, the following steps and guidelines will be introduced into policy and practice June 6, 2016. Week 1: The DNS or designee, will educate and in-service all staff regarding HIPPA rules and regulations of privacy when cares are provided to residents. The DNS or designee will have all staff pass a 10 question written test regarding privacy with a minimum of 8 correct answers. Staff not earning 100 percent</p>		

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F 164	Continued From page 5 with a sheet. The LN then assisted Resident #11 to sit up on the side of the bed and then to stand. Resident #11 was wearing her top shirt and pull ups when she stood up and sat on the wheelchair. On 5/11/16 at 9:50 am, LN #2 acknowledged the window blind was up and the door was open while she was providing nursing care to Resident #11. The LN said she kept Resident #11 covered while she was providing nursing care. She said the area outside the window was fenced and no one could not see Resident 11.	F 164	on the quiz will be counseled and the correct answers will be given and discussed to aid in their understanding of missed concepts. DNS will provide 1 on 1 education and document written counseling with licensed nursing staff referenced in state survey. These quizzes and subsequent documentation will be maintained in the care of the DNS or designee. Weeks 2-5: The DNS or designee will perform random audits on staff during cares 3X per week for 4 weeks and provide staff education for each violation of privacy. Documentation will be maintained and stored in the care of the DNS or designee. Quarterly: The DNS or designee will perform 2 random privacy audits quarterly x2 to ensure staff continues to be compliant with HIPPA privacy rules and privacy regulations. The aforementioned audits will be forwarded to the Governing board quarterly and Quality Assurance Committee monthly. The DNS, or designee is responsible for compliance with this regulation.		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		6/7/16	

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	<p>Continued From page 6</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 allegations of resident abuse by staff were thoroughly investigated. This was true for 2 of 4 allegations of abuse reviewed that were reported to the facility by residents. This resulted in potential harm to Resident #11, who alleged staff abuse on two occasions. Findings include:</p> <p>1. An untitled document, dated 5/4/16 and signed by Physical Therapist #1, documented LN #1 on 5/3/16 "yanked off" Resident #11's left leg geri [protective] sleeve, which caused a skin tear and prompted Resident #11 to "scream" in pain. Physical Therapist #1, who witnessed the alleged incident, stated the observation made her "nauseous [nauseated]."</p> <p>Resident #11's clinical record did not include documentation that the facility's investigation into the allegation included interviews with other residents receiving care from LN #1, evidence that LN #1 was prohibited from direct contact with residents during the investigation, or that Resident #11 was interviewed about the alleged incident.</p> <p>2. An unsigned nurses' note included in a 4/5/16 Incident Report documented Resident #11 had 2 small bruises to her right thigh following cares provided by CNA #3.</p> <p>The Incident Report into Resident #11's bruises failed to include interviews with other residents or</p>		<p>F226 Allegations of Abuse This deficiency has the potential to affect each resident residing at Bell Mountain Care Center. The Facility will follow Safe Haven investigation and Reporting Guidelines. This Safe Haven abuse investigation policy follows all necessary reporting and investigation guidelines required by the Department of Health and Welfare. If followed properly, the policy will help facility management and leadership discover trends in alleged abuses that can reduce future incidences and severity of alleged abuse, and possibly prevent some abuses from occurring though awareness and education. The facility will follow the policy for each investigation and will be reviewed during the facility's weekly Inter departmental Team meeting (IDT). Additionally, all staff will be trained quarterly so they are knowledgeable regarding the abuse policy and qualified to act or assist in abuse investigations with tasks surrounding eye witness statements, as well as the suspension of alleged abusers who are staff members.</p> <p>The IDT review will include whether the proper investigative material and documentation is included and was appropriate. The team will also reevaluate the findings of the investigator, if appropriate. Additionally, an</p>		

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F 226	Continued From page 7 staff concerning cares provided by CNA #3 or whether CNA #3 was prevented from having direct contact with other residents during the investigation. On 5/12/16 at 12:00 pm, the Administrator stated the facility did not interview other residents regarding cares provided by LN #1 or CNA #3, or protect residents in the facility from contact with the two staff members during the investigations.	F 226	investigation log will be implemented to further assist in highlighting potential trends at Bell Mountain. IDT reviews will begin June 7, 2016. The proposed log will include date of alleged abuse, resident involved, staff involved, date of incident, shift the incident occurred, brief description (i.e. res. To res., theft, etc.). The administrator is responsible for compliance with this regulation. The aforementioned audits will be forwarded to the Governing board quarterly and Quality Assurance Committee monthly.		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions;	F 272		6/10/16	

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F 272	<p>Continued From page 8</p> <p>Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</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 residents were assessed as safe to smoke without staff supervision. This was true for 1 of 1 resident who smoked (Random Resident #12) independently and whose last two quarterly assessments documented he required supervision to smoke safely at the facility. This failure created the potential for harm to Random Resident #12 and other residents, staff, and visitors to the facility. Findings included:</p> <p>Random Resident #12 was admitted to the facility 6/30/15 with multiple diagnoses, including convulsions, cognitive deficits, and right-sided hemiplegia.</p> <p>Quarterly smoking assessments dated 6/30/15 and 10/3/15, noted residents with a score greater than 3 required staff supervision while smoking.</p>	F 272	<p>F 272 Comprehensive assessments This deficiency has the potential to affect each resident at Bell Mountain Care Center, especially those that smoke. In addition to adversely affecting resident's health and safety, staff and visitors can also be in danger if a smoking resident is not properly and regularly assessed. To meet the requirements of the regulation, the following steps and guidelines will be introduced into policy and practice by June 10, 2016.</p> <p>The affected resident (resident #12) will be reassessed by a licensed nurse and care plan adjusted, if needed, by June 6, 2016. Additionally, resident #12's lighter and smoking paraphernalia will be stored in the medication cart instead of the room where they reside. This will help assure that resident's safety as well as the</p>		

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F 272	<p>Continued From page 9</p> <p>Random Resident #12's score was 8. The assessment also documented the following:</p> <ul style="list-style-type: none"> * Random Resident #12 had cognitive impairments including "poor safety awareness, impaired short term memory, [and/or] impulsiveness." * Random Resident #12 had "a history of unsafe smoking practices..." * Random Resident #12 "demonstrates noncompliance with smoking policy (i.e. smoking in designated smoking areas only, appropriate disposal of cigarettes, etc.)..." <p>The quarterly assessment, which had not been updated since 10/3/15, documented, "Resident [#12] is unable to smoke safely independently. Resident [#12] requires supervision while smoking... Care plan required."</p> <p>On 5/12/16 at 2:30 pm, CNA #1 stated Random Resident #12 smoked in the designated smoking area "by himself all the time. He's cognitively intact."</p> <p>On 5/12/16 at 2:50 pm, the ADON stated Random Resident #12 kept his own cigarettes and lighter in his room and smoked "3-4 times a day" without supervision. The ADON stated, "He's good and safe to be alone."</p>	F 272	<p>safety of other residents, visitors, and staff is protected.</p> <p>The following are additional steps the facility will follow:</p> <p>Week 1: Licensed staff will be retrained on how to perform an adequate and complete smoking assessment by the Director of Nurses. Also, all current residents who smoke will be assessed by a LN quarterly. Smoking assessments will be reviewed by DNS and care plan changes, if warranted, will be documented in the care plan and implemented.</p> <p>Continuing upon admit and quarterly: Licensed nurses will be assessed quarterly and retrained, if necessary, by the Director of Nursing Services to ensure their proficiency, skill, and the completeness of assessments given. Also, all smoking assessments will be performed by a LN upon admit and quarterly.</p> <p>The assessments will be reviewed by the DNS each quarter and upon admission. The DNS will coordinate with MDS department and will have all assessments posted on a calendar showing when smoking assessments are due, who the smoking assessment is performed on, what date the smoking assessment was performed, and when the next smoking assessment is due.</p> <p>The aforementioned audits will be forwarded to the Governing board</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 272	Continued From page 10	F 272	quarterly and Quality Assurance Committee monthly. The DNS, or designee is responsible for compliance with this regulation.		
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure a smoking care plan was developed for 1 of 1 (#12) sample resident who smoked. This failure created the potential for harm if Resident #12 injured himself while smoking unsupervised and without assistive devices. Findings included:</p>	F 279	<p>F 279 Develop Comprehensive Care Plans This deficiency has the potential to affect each resident at Bell Mountain Care Center, not only those that smoke. Residents care can quickly degrade if appropriate assessments do not lead to</p>	6/10/16	

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F 279	<p>Continued From page 11</p> <p>Resident #12 was admitted to the facility on 6/30/15 with multiple diagnoses, including convulsions, cognitive deficits, and right-sided hemiplegia.</p> <p>Quarterly smoking assessments dated 6/30/15 and 10/3/15 noted residents with a score greater than "3" required staff supervision. Resident #12's score was "8." The assessment also documented the following:</p> <ul style="list-style-type: none"> * Resident #12 had cognitive impairments including "poor safety awareness, impaired short term memory, [and/or] impulsiveness." * Resident #12 had "a history of unsafe smoking practices..." * Resident #12 "demonstrates noncompliance with smoking policy (i.e. smoking in designated smoking areas only, appropriate disposal of cigarettes, etc.)..." <p>The quarterly assessment, which had not been updated since 10/3/15, documented, "Resident [#12] is unable to smoke safely independently. Resident [#12] requires supervision while smoking... Care plan required."</p> <p>On 5/12/16 at 2:30 pm, CNA #1 stated Resident #12 smoked in the designated smoking area "by himself all the time. He's cognitively intact."</p> <p>On 5/12/16 at 2:50 pm, the ADON stated Resident #12 kept his own cigarettes and lighter in his room and smoked "3-4 times a day" without supervision. The ADON stated, "He's good and</p>	F 279	<p>relevant care planning. This has the potential to adversely affect all resident's health and safety. To meet the requirements of this regulation, the following steps and guidelines will be introduced into policy and practice by June 10, 2016.</p> <p>The IDT will meet quarterly to review smoking care plans as well as the quarterly MDS driven assessments. The IDT will write individual and appropriate care plans addressing specific needs for each resident based upon the most current assessments done that quarter performed by LN. The DNS or designee will provide staff education in the form of a written in-service for all changes in smoking status or acuity. The care plan will be updated quarterly by the IDT to reflect any changes in the current smoking or ADL/Acuity assessments. The MDS coordinator will be notified of any changes (in writing) with smoking or ADL/Acuity status and protocol for all residents by the IDT. MDS Coordinator will then update the care plans regularly. Any care plan update occurring during the previous week will be reviewed by the IDT the following week. The aforementioned audits will be forwarded to the Governing board quarterly and Quality Assurance Committee monthly. The DNS, or designee is responsible for compliance with this regulation.</p>		

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F 279	Continued From page 12 safe to be alone."	F 279			
F 280 SS=D	Resident #12's clinical record did not include a smoking care plan. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to revise care plans for 1 of 10 sampled residents (#2). This had the potential to result in harm if the resident did not receive appropriate care due to lack of direction in the care plan. Findings included:	F 280	F 280 Resident Right to Participate in Planning Care. This deficiency has the potential to affect each resident at Bell Mountain Care Center. Residents care will degrade and harm will occur if relevant care planning does not lead to consistency in the level	5/13/16	

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F 280	<p>Continued From page 13</p> <p>Resident #2 was admitted to the facility on 11/4/14 with diagnoses that included supranuclear palsy [a rare neurodegenerative disease with similar symptomology to Parkinson's Disease].</p> <p>Resident #2's care plan was updated 2/16/16 after the resident fell during a one staff assisted transfer. The updated care plan documented two staff were to assist Resident #2 with transfers.</p> <p>An undated CNA Guide in use by staff at the time of survey (5/9/16 - 5/13/16) documented one staff was required for Resident #2's transfers.</p> <p>On 5/12/16 at 11:00 am, the ADON stated Resident #2 would not allow two staff to assist with transfers, but was safe with a one staff transfer assist. The ADON stated the facility would update the resident's care plan for one staff to assist with transfers.</p> <p>On 5/12/16 at 11:30 am, PT #1 stated Resident #2 was safe with one staff providing transfer assistance and did not require two staff members to transfer safely.</p>	F 280	<p>of care the resident receives. This has the potential to adversely affect all resident's health and safety. To meet the requirements of this regulation, the following steps and guidelines will be introduced into policy and practice by June 10, 2016. Additionally, the care plan was revised for resident #2 to include one person assist on May 13, 2016.</p> <p>If a resident expresses wishes that are contrary to the existing, current care plan, the physician, DNS (or designee), POA, family member or guardian, and Administrator will be notified.</p> <p>The resident care plan collaborative suggestion will be evaluated in the next, weekly IDT meeting.</p> <p>Care plan will be altered per resident's collaborative suggestion if approved. This may also involve extensive training for caregiving and licensed staff. If so, group in services will be held by DNS or designee to update staff on the most recent changes to the care plan and caregiving techniques where applicable. Additionally, all staff will be trained and retrained on the care plan adjustment protocol during regularly scheduled in-services. Also, if the suggestions are not approved by the physician or representatives from the facility or family, the State Ombudsman will be contacted for assistance.</p> <p>The aforementioned audits will be forwarded to the Governing board quarterly and Quality Assurance</p>		

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F 280	Continued From page 14	F 280	Committee monthly. The DNS, or designee is responsible for compliance with this regulation.		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure medications were not initialed as given on the Medication Administration Record prior to administration of the medications. This was true for 3 of 5 (#3, #7, and #11) sampled residents observed during medication pass. This failed practice had the potential for harm if residents did not receive prescribed medications for the medical condition. Findings included:</p> <p>1. On 5/11/16 LN #2 was observed to pre-initial the MAR prior to actual administration of the medications to the following residents:</p> <p>*8:45 am: Resident #13's medications, including ASA 81 mg, Zocor 20 mg and Zestorelic 10/12.5, one half tab.</p> <p>*9:10 am: Resident #7's medications, including Losartan 50 mg, Simvastatin 20 mg, ASA 81 mg and Humalog 10 units.</p> <p>*9:35 am: Resident #11's medications, including Lasix 40 mg, Pepcid 20 mg, Metoprolol 12.5 mg, Aricept 5 mg, KCl 10 meq, Senna 8.6 mg,</p>	F 281	<p>F 281 Services Provided Meet Professional Standards.</p> <p>This deficiency has the potential to adversely affect each resident, and the potential for harm at Bell Mountain Care Center. It is against the medication administration policy of Bell Mountain Care Center to pre-initial the MAR when giving medications to residents. To meet the requirements of this regulation, the following steps and guidelines will be introduced into policy and practice by June 10, 2016.</p> <p>Week 1 DNS will request med pass audit form from facility pharmacy to utilize during audits. In-service on proper med pass procedure will be given to all LN staff during the June LN staff meeting (June 7, 2016). DNS will have all LN staff pass a 10 question written test regarding privacy with a minimum of 8 correct answers. However, staff will be counseled for uncorrected responses to ensure</p>	6/10/16	

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F 281	Continued From page 15 Aldactone 25 mg Lexapro 20 mg and Tizanidine 2 mg. On 5/11/16 at 9:50 am, LN #2 confirmed that she initialed each resident's MAR prior to actual administration of the medications.	F 281	understanding of the material. Discuss med pass procedure audit form to LN staff DNS will provide 1 on 1 education and document written counseling with LN referenced in state audit. Week 2-5 DNS or ADON will perform med pass audit on each nurse two times during 4 week period. All LN staff will be educated when violating a procedure and documentation will be placed in LN employee file. Repeat violators of med pass audits will meet with DNS for written oral documentation of violation. DNS and LN will agree on a written action plan to resolve present violations and prevent further violations. DNS and LN will sign agreement. Further discipline action could occur if written action plan is not followed or does not stop violations. Quarterly x2: DNS or ADON will perform med pass audit 2x each quarter. All LN staff will be educated when violating a procedure and documentation will be placed in LN employee file. LN will meet with DNS when repeating med pass audits violations for written oral documentation of violation. DNS and LN will agree on a written action plan to resolve present violations and prevent further violations. DNS and LN will sign agreement.		

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F 281	Continued From page 16	F 281	Further discipline action could occur if written action plan is not followed or does not stop violations. Additionally, the licensed nurse that was observed pre-initialing the MAR was counseled, in serviced, and provided additional training. This nurse was also disciplined in accordance with Bell Mountain Care Center's progressive discipline policy. The aforementioned audits will be forwarded to the Governing board quarterly and Quality Assurance Committee monthly. The DNS, or designee is responsible for compliance with this regulation.		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents with indwelling urinary catheters were provided with applicable cares. This was	F 315	F 315 No Catheter, Prevent UTI, Restore Bladder (part 1) This deficiency has the potential to affect each resident at Bell Mountain Care	6/10/16	

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F 315	<p>Continued From page 17</p> <p>true for 1 of 1 resident in the facility with a Foley catheter (#4) and had the potential to cause harm, including development of urinary tract infections. The facility also failed to ensure residents were toileted per care plan direction. This was true for 1 of 4 (#3) residents reviewed for urinary incontinence. This created the potential for harm if the residents' continence status declined, skin was compromised from prolonged exposure to urine, or residents experienced psychosocially embarrassing incidents of incontinence. Findings include:</p> <p>Resident #4 was admitted to the facility on 2/24/14 with diagnoses that included bladder stones, BPH, and urinary retention.</p> <p>Physician Orders, dated 2/26/14 and still in effect at the time of the facility's recertification survey (5/9/16 - 5/13/16) documented, "Foley Care [every] shift - Pull meatus back from catheter and cleanse around Foley insertion site with clean moist cloth or wipe."</p> <p>Resident #4's urinary elimination care plan, dated 2/18/16, documented staff were to provide catheter cares every shift and PRN.</p> <p>Physician Order Flow Sheets for February, March, and April 2016 documented catheter care was not provided as follows:</p> <p>* February 2016:</p> <p>-Day Shift - 2/6, 2/13-14, 2/18-21, and 2/26-27 -Evening Shift - 2/6, 2/13, 2/20, and 2/26-27 -Night Shift - 2/5-6, 2/20, and 2/26-27.</p>	F 315	<p>Center. Residents care will degrade and harm will occur if proper care and treatment is not provided that will aid in the prevention of urinary tract infections and restore as much normal bladder function as possible. Further, residents that have indwelling catheters must receive the proper care and treatment upon every nursing shift and that care must be documented. To meet the requirements of this regulation, the following steps and guidelines will be introduced into policy and practice by June 10, 2016. To be sure the resident mentioned in this deficiency is receiving the care needed, the C.N.A. staff was interviewed. The care was provided but not properly documented. The staff was immediately instructed to begin documenting the cares given to this resident in order to achieve compliance with this regulation.</p> <p>Weeks 1-4: DNS will in-service all nursing staff on proper documentation after catheter care is performed. DNS or ADON will audit C.N.A. documentation daily X 4 weeks. All missed catheter care documentation will be reported to DNS. DNS will meet with all staff who repeat missing catheter care documentation 2 times for oral discipline and discuss plan to resolve documentation problem with further meetings if needed.</p> <p>Week 5-8:</p>		

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F 315	<p>Continued From page 18</p> <p>* March 2016:</p> <p>-Day Shift - 3/5, 3/11-12, 3/14, 3/17-18, 3/20, and 3/23 -Evening Shift - 3/2, 3/5, 3/12, 3/14, 3/21, and 3/28 -Night Shift - 3/5, 3/12-13, 3/16-18, 3/23-26, and 3/30</p> <p>* April 2016:</p> <p>-Day Shift - 4/11 and 4/30 -Evening Shift - 4/2, 4/8, 4/16, 4/22, and 4/30 -Night Shift - 4/1 and 4/8.</p> <p>On 5/11/16 at 10:35 am, when asked about the lack of physician-ordered and care planned catheter care for Resident #4, the ADON stated the facility's failure to provide those cares was "unacceptable."</p> <p>2. Resident #3 was admitted to the facility on 3/7/15 with multiple diagnoses, including osteoporosis and hypertension.</p> <p>Resident #3 most recent Annual MDS assessment, dated 2/12/16, documented she required one person physical assist for all activities of daily living and set-up only for eating.</p> <p>Resident #3's 3/16/16 care plan documented, "Risk for altered patterns of urinary/bowel elimination." Interventions in place were for staff to encourage/assist resident to toilet before and after meals, HS, and PRN, bowel protocol per facility protocol..."</p> <p>On 5/12/16 the following was observed:</p>	F 315	<p>DNS will audit C.N.A. documentation every Thursday X 4 weeks. DNS will provide staff education for any missed documentation of catheter cares. DNS will meet with staff who repeat missing catheter care documentation 2 times for oral discipline and discuss plan to resolve documentation problem with further meetings if needed.</p> <p>Monthly x2: DNS will audit C.N.A. documentation first week following the end of the month. DNS will provide staff education for any missed documentation of catheter cares. DNS will meet with staff who repeat missing catheter care documentation 2 times for oral discipline and discuss plan to resolve documentation problem with further meetings if needed. The aforementioned audits will be forwarded to the Governing board quarterly and Quality Assurance Committee monthly. The DNS, or designee is responsible for compliance with this regulation.</p> <p>F 315 No Catheter, Prevent UTI, Restore Bladder (part 2) This deficiency has the potential to cause harm to each resident residing at Bell Mountain. Staff was immediately in serviced upon learning of the facility's noncompliance with this regulation. However, the following will aid in creating a system of future compliance.</p> <p>Week 1:</p>		

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F 315	Continued From page 19 *8:20 am, Resident #3 was observed in the common area, sitting in the recliner with her eyes closed and the television was on. *9:35 am to 10:11 am, Resident #3 was observed sleeping in the recliner. *10:25 am, CNA #2 approached and woke Resident #3 to tell her she would have to leave at 10:45 am to go to the Senior Center. Resident #3 asked the CNA what time it was, CNA said, "10:25 am." Resident #3 told the CNA that she would like to wait in the common area. The CNA was not heard to offer or ask Resident #3 if she would like to go to the bathroom. *Between 10:40 am to 10:58 am, Resident #3 was observed with RNA #4 doing PROM exercises of her upper extremities while sitting in the recliner. At 10:50 am she was observed walking in the hallway using her front wheel walker with RNA #4 behind her. At 10:58 am, Resident #3 was sitting in the wheelchair when RNA #4 pushed her to her room and assisted her to put on her sweater and combed her hair. The RNA was not heard to offer or ask the Resident #3 if she would like to go to the toilet before going to the Senior Center. At 11:15 am, Resident #3 left the facility without going to the toilet. On 5/12/16 at 2:07 pm, the ADON said the CNAs should have offered the Resident #3 use of the toilet before going to the Senior Center.	F 315	A LN will perform a B&B assessment on all residents. The IDT will review all toileting care plans and adjust care plans to reflect residents needs from current B&B assessment. DNS will in-service staff on toileting care plans for all residents. Quarterly: A LN will perform a quarterly B&B assessment on all residents. The IDT will meet quarterly and review all toileting care plans and adjust care plans to reflect residents' needs from current B&B assessment. DNS will in-service staff on toileting care plans for all residents. Special care will be taken in order to adequately maintain the toileting care plans for traveling residents or those that are scheduled for appointments or excursions. The aforementioned audits will be forwarded to the Governing board quarterly and Quality Assurance Committee monthly. The DNS, or designee is responsible for compliance with this regulation. In addition to the various audits performed by the DNS or designee, the charge nurses will perform two hour toileting checks as part of their toileting rounds each day. Each charge nurse will be trained and retained in in-services at least quarterly.		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		6/10/16	

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 05/13/2016
NAME OF PROVIDER OR SUPPLIER BELL MOUNTAIN VILLAGE & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 620 NORTH SIXTH STREET BELLEVUE, ID 83313		
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F 329	<p>Continued From page 20</p> <p>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.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure that physician's orders were clarified. This was true for 1 of 9 (#5) sampled residents residing in the facility. This failure created the potential for harm if resident was to receive unnecessary medications and to experience adverse consequences related to unnecessary medications. Findings include:</p>	F 329	<p>F 329 Drug Regimen is Free from Unnecessary Drugs This deficiency has the potential to affect each resident at Bell Mountain Care Center. Residents care will degrade and harm will occur if each resident's drug regimen is not free from unnecessary or discontinued drugs. To meet the requirements of this regulation, the</p>		

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F 329	Continued From page 21 Resident #5 was admitted to the facility on 2/12/16 with multiple diagnoses, including hypertension. Resident #5's 3/22/16 physician's visit note documented the resident was to received Hydralazine 25 mg every other day for hypertension... and to stop taking hydrochlorothiazide [HCTZ] (hydrodiuril) 25 mg PO every morning..." Resident #5's April and May 2016 MAR documented the resident was administered HCTZ 25 mg 1 PO QOD and Hydralazine 25 mg BID. Resident #2 continued to receive HCTZ, although at a different frequency. Resident #2 also received Hydralazine BID instead of every other day, as ordered. On 5/11/16 at 2:20 pm, the physician's order was shown to the ADON. She said the LN who received the orders should have called the physician and clarified the orders on Hydralazine and the HCTZ should have been discontinued.	F 329	following steps and guidelines will be introduced into policy and practice by June 10, 2016. Additionally, the physician's orders were clarified by the nurse to clear up the ambiguity. Upon learning of this deficiency, nursing administration immediately investigated the two residents' medical records cited in the deficiency. The doctor's orders were clarified and the unnecessary drugs were discontinued per physician's instructions. Week 1-2: Facility Convert to 3 part provider order forms. DNS to train all LN on proper procedure for writing a provider order. Train all LN on proper procedure for processing a provider order. Continuously: Copy of all orders will be placed in DNS office. All orders will be checked daily by DNS or ADON to confirm that: The 6 R's of med orders are on written correctly on all provider orders. Right Resident, Right Route, Right Time, Right Dose, Right Route and Right Reason. All new orders are written correctly on MAR or TAR. All appropriate meds are DC'd correctly. All new meds ordered are in building. All new meds are labeled with the 6 R's of med pass. All DC'd meds are removed from med cart.		

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

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F 329	Continued From page 22	F 329	Monthly: All monthly recaps will be performed by DNS and ADON each month. MDS will print MARS and TARS one to two days before end of month to allow DNS and ADON time to properly note all recaps. The aforementioned audits will be forwarded to the Governing board quarterly and Quality Assurance Committee monthly. The DNS, or designee is responsible for compliance with this regulation.		
F 431 SS=E	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.	F 431		6/10/16	

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F 431	<p>Continued From page 23</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure expired biological supplies (test tubes for blood draws) were removed from resident use. This failure created the potential for inaccurate laboratory results if blood was drawn in expired laboratory test tubes. Findings included:</p> <p>On 5/10/16 at 3:15 pm, during the inspection of the supply drawer with LN #3 the following vacutainers were found:</p> <ul style="list-style-type: none"> * 19 Blue top tubes which expired June 2015 * 2 Red top tubes which expired Nov 2015 * 20 Light Green top tubes which expired Nov 2015 * 10 Gray top tubes which expired Dec 2015 * 13 Yellow top tubes which expired Dec 2015 * 18 Tiger top tubes which expired Dec 2015 * 1 Purple top tubes which expired Jan 2016 * 92 Yellow top tubes which expired Feb 2016 * 96 Green top tubes which expired Feb 2016 <p>LN #3 confirmed the expiration dates of the</p>	F 431	<p>F 431 Drug Records Label/Store Drugs & Biologicals This deficiency has the potential to affect each resident at Bell Mountain Care Center. The out of date lab supplies were immediately removed from the building during the state survey (May 11, 2016) upon discovering the deficiency. Additionally, Bell Mountain was fortunate enough locate a trained RN with experience in creating compliant infection control programs in the State of Idaho. Also, in order to meet the requirements of this regulation, the following steps and guidelines will be introduced into policy and practice by June 10, 2016.</p> <p>Week 1: Weekend nurse will do weekly audits for expired meds and medical supplies. Weekend nurse will remove all expired product. DNS, or designee, in conjunction with Pharmacist will make the determination</p>		

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F 431	Continued From page 24 laboratory test tubes.	F 431	as to what, and how these items will be discarded. The aforementioned audits will be forwarded to the Governing board quarterly and Quality Assurance Committee monthly. The DNS, or designee is responsible for compliance with this regulation.		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441		6/27/16	

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F 441	<p>Continued From page 25 hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and review of policy and procedures for hand washing and handling of dirty linen, it was determined the facility failed to ensure staff demonstrated proper hand washing and handling of dirty linen. This directly impacted 1 random resident (#11) whose pericare was observed and the potential to place all residents at risk for infections due to cross-contamination. Findings include:</p> <p>1. On 5/11/16 at 9:10 am, during the Medication Pass, LN #2 was observed to put Resident #11's Calcium tablet in the pill cutter. She took the Calcium bottle cap with her left hand and used it to position the tablet in the pill cutter which was being held by her right hand. LN #2 was unable to position the tablet correctly using the bottle cap and proceeded to crush the tablet instead.</p> <p>On 5/11/16 at 9:50 am, LN #2 acknowledged not wearing a pair gloves when she was trying to cut the Calcium tablet. She added that she did not touch the Calcium tablet with her bare hands but instead was keeping it in placed using the bottle cap.</p>	F 441	<p>F 441 Infection Control Program This deficiency has the potential to affect each resident at Bell Mountain Care Center. The nurse that demonstrated improper handwashing protocol was immediately counseled and in serviced on the proper Bell Mountain Infection control, handwashing policy. In order to meet the requirements of this regulation, the following steps and guidelines will be introduced into policy and practice by June 10, 2016.</p> <p>Week 1: Infection control nurse will in-service all nurse staff on proper handwashing procedures. DNS will provide 1 on 1 education and document written counseling with LN referenced in state audit.</p> <p>Week 2-4: All nursing staff members will demonstrate proper hand washing procedures to Infection control nurse.</p>		

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F 441	<p>Continued From page 26</p> <p>2. On 5/11/16 at 9:35 am, LN #2 was observed providing nursing care to Resident #11 prior to administration of her medications. Resident #11 was lying in bed with a sheet covering her body from her waist down and her legs were bent. LN #2 put on a pair of disposable gloves and removed Resident #11's soiled pull ups and cleaned the resident's private parts using sanitary wipes. She then put clean pull ups on Resident #11 afterwards. The LN removed her gloves and assisted the resident to transfer from her bed to the wheelchair, and put put Resident #11's pills on the apple sauce and gave it to her. LN was not observed to wash her hand after removing her gloves.</p> <p>On 5/11/16 at 9:50 am, LN #2 said she usually washed her hand after removing her gloves but might have missed it earlier when she was with Resident #11.</p> <p>The facility's Policy and Procedure for Infection Control Handwashing documented, "Appropriate ten (10) to (15) second hand-washing must be performed under the following conditions: ...d. Before preparing or handling medications...i. Between resident contacts j. Between tasks or procedures on the same resident...l. After removing gloves...o. upon completion of duty"</p> <p>3. On 5/11/16 at 11:30 am, during the tour of the laundry room, the Laundry personnel was asked to describe the steps taken when handling the dirty linen. The Laundry personnel said, she put on a pair of disposable gloves and extended her arms as she sorted out the dirty linen to ensure none of the dirty linen came in contact with her</p>	F 441	<p>The Infection Control Nurse will have all staff pass a 10 question written test regarding proper handwashing a minimum of 8 correct answers. However, staff will be counseled for incorreced responses to ensure understanding of the material.</p> <p>Quarterly x2: All nursing staff members will demonstrate proper hand washing procedures to Infection control nurse. The Infection Control Nurse will have all staff pass a 10 question written test regarding proper handwashing a minimum of 8 correct answers. However, staff will be counseled for incorreced responses to ensure understanding of the material.</p> <p>Continuously: All new hires will be educated to proper handwashing by Infection Control Nurse. All new hires will demonstrate proper handwashing procedures to Infection Control Nurse. All new hires will staff pass a 10 question written test regarding proper handwashing a minimum of 8 correct answers. However, staff will be counseled for incorreced responses to ensure understanding of the material.</p> <p>The aforementioned audits will be forwarded to the Governing board quarterly and Quality Assurance Committee monthly. The DNS, or designee is responsible for compliance with this regulation.</p>		

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F 441	Continued From page 27 clothes or skin, only her gloved hand. When asked if she was wearing a gown or clothing protector, the laundry personnel said, "No."	F 441	<p>In addition to the audits being regularly preformed, the DNS or designee will add monitoring of hand washing to weekly, general focused rounds. This will be instrumental in the observation of correct hand washing techniques on the floor. If during general rounds, it is found a care giver, C.N.A., or LN did not follow the proper infection control procedures, corrective guidance will be immediately provided by the DNS or designee.</p> <p>Also, Bell Mountain will provide proper protective attire to staff performing linen sorting duties. Ongoing training will also be provided upon new hire, quarterly in-services, and general observation on the floor.</p> <p>Each housekeeper will be in serviced on how to properly sort dirty linens per the Bell Mountain infection control policy. In conjunction to the training with protective equipment, The DNS, or designee (infection control nurse)will audit the laundry sorting task weekly, and then then for two quarters. Additionally, staff will be watched weekly during the sorting task to see if they are compliant with the infection control policy regarding linen sorting. This task will be added to weekly focused rounds in order to monitor in real time. DNS, Infection Control Nurse, or designee will continue to monitor on an ongoing basis.</p>		

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F 441	Continued From page 28	F 441	<p>F 441 Continued: Infection Control with Med Pass All LNs will be educated on Med Pass procedures including handwashing before passing medications as well as not touching medications without first applying gloves. DNS will provide 1 on 1 education and document written counseling with LN staff.</p> <p>Week 2-4: All nursing staff members will demonstrate proper med pass procedures to DNS. The DNS will have all staff pass a 10 question written test regarding proper med pass procedures. A minimum of 8 correct answers is passing. However, staff will be counseled for incorrected responses to ensure understanding of the material.</p> <p>Quarterly x2: All nursing staff members will demonstrate proper med pass procedures to DNS. The DNS will have all staff pass a 10 question written test regarding proper handwashing a minimum of 8 correct answers is passing.</p> <p>Continuously: All new hires will be educated on proper med pass procedures by DNS. All new hires will demonstrate proper med pass procedures to DNS.</p>		

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F 441	Continued From page 29	F 441	<p>All new hires will staff pass a 10 question written test regarding proper med pass procedure; a minimum of 8 correct answers is passing. However, staff will be counseled for incorreceted responses to ensure understanding of the material.</p> <p>The aforementioned audits will be forwarded to the Governing board quarterly and Quality Assurance Committee monthly. The DNS, or designee is responsible for compliance with this regulation.</p>		

Bureau of Facility Standards

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C 268	<p>02.107,01 Dietary Service</p> <p>107. DIETARY SERVICE.</p> <p>01. Dietary Supervision. A qualified food service supervisor shall be designated by the administrator to be in charge of the dietary department. This person shall: This Rule is not met as evidenced by: Based on staff interview, it was determined the facility did not ensure the food service supervisor was qualified for the position. This had the potential to affect 1 of 9 (#s 1-9) sampled residents and all the residents residing in the facility. Findings included: On 5/11/16 at 10:10 am, the FSS said he will complete his food service training in February 2017.</p>	C 268	<p>C 268 Dietary Qualifications This deficiency has the potential to affect each resident at Bell Mountain Care Center. However, the current Dietary manager is actively enrolled and participating in Idaho's AAFP certification for dietary managers. This class is scheduled to be completed spring 2017. Additionally, a registered dietician has been retained and visits Bell Mountain regularly each week to help insure the residents are receiving proper nutrition per the state regulations. Since Bell Mountain Care Center must be in compliance with this regulation before February 2017, a qualified manager will be recruited or our consultant will be retained to work additional hours per week in order to have 40 hours of qualified dietary management.</p>	7/1/16
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative.</p>	C 664		6/7/16

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

TITLE

(X6) DATE
06/06/16

Bureau of Facility Standards

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C 664	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on staff interview and review of Infection Control Committee records, it was determined the facility failed to ensure a representative from each department attended the Infection Control Meetings at least quarterly. The lack of participation of all departments created the potential for negative outcomes for residents, visitors and staff in the facility. Findings included:</p> <p>On 5/11/16 at 8:00 am, the facility's Infection Control Committee minutes was reviewed. Upon review of the sign in sheets, it was determined the following departments were not represented:</p> <ul style="list-style-type: none"> * Housekeeping for March 2016 meeting * DON, Maintenance, Housekeeping for April 2016 meeting <p>On 5/12/16 at 2:07 pm, the ADON said she they were to have a monthly Infection Control meetings. She was not able to find more records of previous meetings held for 2015.</p>	C 664	<p>C 664 Required Quality Assurance Committee This deficiency has the potential to affect each resident at Bell Mountain Care Center. The quality Assurance committee will be made up of the Medical Director, Administrator, Pharmacist, dietary services supervisor, DNS, housekeeping services coordinator, and the maintenance services representative. This committee convenes monthly and will include the personnel previously listed.</p>	
C 666	<p>02.150,02,c Quarterly Committee Meetings</p> <p>c. Meet as a group no less often than quarterly with documented minutes of meetings maintained showing members present, business addressed and signed and dated by the chairperson.</p> <p>This Rule is not met as evidenced by: Based on the review of the Infection Control Meeting Minutes and staff interview, it was determined the facility failed to ensure a quarterly Infection Control Meetings were held. This affected 9 of 9 residents (#s 1-9) sampled residents and all the residents residing in the facility. Findings included:</p>	C 666	<p>C 666 Quarterly Committee Meetings. This deficiency has the potential to affect each resident at Bell Mountain Care Center. The facility will hold quarterly infection control meetings. There has been an uncharacteristic amount of turnover at the management level. Bell</p>	6/10/16

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 05/13/2016
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NAME OF PROVIDER OR SUPPLIER BELL MOUNTAIN VILLAGE & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 620 NORTH SIXTH STREET BELLEVUE, ID 83313
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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) COMPLETE DATE
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C 666	Continued From page 2 On 5/12/16 at 2:07 pm, the ADON provided the copy of the Infection Control Minutes, the last two meetings were held on March and April 2016. The ADON said no other meetings had been held.	C 666	Mountain now has the staff and organization requisite for compliance with this regulation. However, the quarterly committee meetings are calendared and the calendar, as well as contact numbers will be listed in each committee binder for future reference no matter the change in top leadership. This will help maintain consistent committee input despite staffing changes.	
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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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May 26, 2016

Rob Deloach, Administrator
Bell Mountain Village & Care Center
620 North Sixth Street,
Bellevue, ID 83313-5174

Provider #: 135069

Dear Mr. Deloach:

On **May 13, 2016**, an unannounced on-site complaint survey was conducted at Bell Mountain Village & Care Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007100

The complaint was investigated during the facility's re-certification survey of May 9, 2016 through May 13, 2016.

During the survey, meal preparation was observed and dietary orders compared to meals received by residents on specialized diets. No discrepancies between specialized diets ordered and received by residents were observed.

Two meals were also observed during the re-certification survey without any noted concerns; residents requiring help with their meals were observed receiving the assistance they required at both meals.

Individual interviews with residents and residents' family members, as well as a group interview with six residents present, did not reveal any concerns with specialized diets or staff-provided eating assistance.

Allegation #1: The Reporting Party stated that on July 9, 2015 an identified resident did not receive the mechanical soft diet she had been ordered, nor the eating assistance she required.

Findings #1: The facility's Grievance File for the look back period did not contain any resident or family concerns with adequate eating assistance or specialized diets.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The Reporting Party stated on the evening of July 9, 2015, only one Certified Nursing Aide was in the Hemingway House building of the facility to provide eating assistance to those residents who required this type of aid. Because of this staffing-to-resident ratio, the Certified Nursing Aide was unable to provide adequate assistance to those residents who needed it during the evening meal.

Findings #2: The facility's staffing records were reviewed for the three-week look back period during the facility's re-certification survey. The facility's staffing for this time span exceeded the state requirement. Additionally, there were no concerns with staffing levels expressed by residents or family members, and the facility's Grievance File for the look back period did not contain concerns related to staffing levels.

Observations conducted throughout the facility's re-certification survey, May 9, 2016 through May 13, 2016, did not reveal concerns involving adequate staffing levels or assistance provided to residents.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The Reporting Party stated the Hemingway House building had only one Certified Nursing Aide on duty the evening of July 9, 2015 and that this aide was occupied with his/her duties in the dining room, which prevented a timely response to call lights elsewhere in the building.

Findings #3: There were no concerns with staffing levels or call light response times expressed by residents or family members, and the facility's Grievance File for the look back period did not contain concerns related to inadequate staffing levels or untimely call light response times.

Observations conducted throughout the facility's re-certification survey, May 9, 2016 through May 13, 2016, did not reveal concerns involving inadequate staffing levels, insufficient assistance provided to residents, or unacceptable staff response times to resident call lights.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Rob Deloach, Administrator
May 26, 2016
Page 3 of 3

Allegation #4: The Reporting Party stated building temperatures are "a problem" and in late June 2015 an unidentified male resident was sent to the hospital for a "heat-related illness." Other residents and staff also complained of uncomfortably warm temperatures in the facility.

Findings #4: During the facility's re-certification survey of May 9, 2016 through May 13, 2016, individual resident rooms and common areas in both the Hemingway and Galena buildings were monitored for uncomfortably warm or cold temperatures. The temperatures in both individual resident rooms, as well as common areas, were noted to be at a comfortable level.

Individual interviews with residents and residents' family members, as well as a group interview with six residents present, did not reveal any concerns with uncomfortably warm- or cold temperatures. There were no concerns expressed in the facility's Grievance File for the look back period.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

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

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt