IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

July 11, 2016

Tara Hatfield, RN, Administrator
Valley Vista Care Center of Sandpoint
220 South Division
Sandpoint, ID 83864-1759

Provider #: 135055

Dear Ms Hatfield:

On **June 23, 2016**, a survey was conducted at Valley Vista Care Center of Sandpoint by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes 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.

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 **July 21, 2016**. Failure to submit an acceptable PoC by **July 21, 2016**, may result in the imposition of penalties by **August 10, 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 <u>in column (X5)</u>.

  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 **July 28, 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 **September 21, 2016**. A change in the seriousness of the deficiencies on **August 7, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 21, 2016** includes the following:

Denial of payment for new admissions effective **September 21, 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 **December 20, 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 **September 21, 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

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 **July 21, 2016**. If your request for informal dispute resolution is received after **July 21, 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,

Nina Sanderson, LSW, Supervisor
Long Term Care

NS/lj
Enclosures

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **135055** | | **06/23/2016** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **VALLEY VISTA CARE CENTER OF SANDPOINT** | **220 SOUTH DIVISION**<br>**SANDPOINT, ID 83864** |

| (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<br><br>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from June 20, 2016 to June 23, 2016.<br><br>The surveyors conducting the survey were:<br>Linda Kelly, RN, Team Coordinator<br>Amy Youngman, RN<br>Linda Roper, RN<br><br>Definitions and Abbreviations:<br>BM = bowel movement<br>CMP = complete metabolic profile<br>DON = Director of Nursing<br>LPN = Licensed Practical Nurse<br>FYI = For your information<br>IDPN = Interdisciplinary Progress Notes<br>MAR = Medication Administration Record<br>mcg = microgram<br>mg = milligram<br>PRN = As Needed | F 000 | | |
| F 309<br>SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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 and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to ensure 3 of 15 sampled residents | F 309 | Corrective Action: | 7/27/16 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 07/21/2016 |

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 309 | Continued From page 1<br>(#5, #8, and #11) received care and services required to meet their highest practicable level of physical well-being. This deficient practice created the potential for adverse outcomes for Resident #5 and Resident #8 when they were administered PRN pain medications without specific orders for administration parameters. Resident #8 was placed at risk of adverse events when she went 16 days without having a bowel movement without intervention. Findings include:<br><br>1. Resident #5"s "Face Sheet" indicated he was readmitted to the facility on 5/31/16, with diagnoses including a history of fall, left femur fracture, and dementia.<br><br>Resident #5's significant change MDS assessment, dated 6/7/16, documented he had experienced a recent fall with injury and was displaying verbal or facial indicators of pain three to four days per week.<br><br>Resident #5's Physician's Orders, dated 6/2016, included the following pain management orders:<br><br>-Fentanyl Duragesic Patch 25 mcg (a pain medication patch applied to the skin) to be applied every 72 hours for pain.<br><br>-Hydrocodone/Acetaminophen 5/325 mg (a narcotic pain medication) one tablet by mouth every four hours as needed for pain.<br><br>-Oxycodone (a narcotic pain medication) 5 mg by mouth every two hours as needed for pain.<br><br>-Oxycodone 10 mg by mouth every two hours as needed for pain. | F 309 | On 7/20/2016, The DON sent a fax communication to resident #5's and resident #11's attending physicians requesting clarification order outlining parameters detailing, based on pain rating, when to administer which particular medication and at which dose. Additionally, A Universal Pain Assessment tool which includes assessment parameters for both cognitively/verbally intact residents and cognitively/verbally impaired residents was placed in all medication administration records.<br><br>On 6/23/2016 , the DON notified the attending physician of resident #8's irregular bowel status. He acknowledged notification via fax correspondence. No new orders were received. Resident #8 is no longer a resident of this facility.<br><br>Other residents:<br><br>All residents with orders for PRN pain medications have the potential to be affected by this deficient practice. The DON performed an audit of all current residents' pain medication orders on 7/20/2016. The attending physicians of all residents identified as having PRN analgesic orders without parameters detailing, based on pain rating, when to administer which medication and at which dose will be queried for clarification by 7/21/2016. | |

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| F 309 | Continued From page 2<br><br>-Oxycodone 15 mg by mouth every two hours as needed for pain.<br><br>-Oxycodone 20 mg by mouth every two hours as needed for pain.<br><br>-Tylenol 325 mg one tablet by mouth every four hours as needed for pain.<br><br>-Tylenol 325 mg two tablets by mouth every four hours as needed for pain.<br><br>-Check resident for pain every four hours and prn (as needed).<br><br>Resident #5's MARs for 6/2016 documented the following:<br><br>-Hydrocodone/Acetaminophen 5/325 one tablet was administered to Resident #5 on 6/3/16 (twice), 6/6/16, 6/9/16, 6/10/16, 6/11/16, 6/14/16, 6/16/16, and 6/20/16 (once per day). Notation on the back of the MAR indicated the medication was administered for pain. Documentation of the severity of pain Resident #5 was experiencing prior to administration of the medication could not be found in his medical record. Results of the medication administration were documented as "helpful."<br><br>-Oxycodone 5 mg was not administered to Resident #5 in 6/2016 per the MAR.<br><br>-Oxycodone 10 mg was administered to Resident #5 on 6/1/16 and 6/6/16. Notation on the back of the MAR stated the medication was administered for pain. Documentation of the severity of pain | F 309 | All residents have the potential to be affected by the deficient practice of failure to notify attending physician of irregular bowel status. An audit of all current resident bowel monitors will be conducted by the bowel and bladder nurse by 7/22/2016 to ensure that all irregularities have been reported to the appropriate attending physicians.<br><br>Facility systems:<br><br>Beginning 7/22/2016, licensed nurse staff will be instructed to obtain clarification orders for any new PRN analgesics that are ordered without parameters detailing, based on pain rating, when to administer which medication and at which dose. Additionally beginning 7/20/2016, licensed nurse staff will be instructed on proper use of the Universal Pain Assessment Tool in determining proper medication administration.<br><br>Beginning 7/22/2016, each resident's medication administration record will be updated to include per-shift monitoring of resident bowel status and status of physician notification as applicable.<br><br>Monitoring:<br><br>Beginning the week of 7/24/2016, the DNS or her designee will perform audits of a sample group of residents' medical records to ensure that PRN medication | |

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| F 309 | Continued From page 3<br>Resident #5 was experiencing prior to administration of the medication could not be found in his medical record. Results of the medication administration were documented as "helpful."<br><br>-Oxycodone 15 mg was administered to Resident #5 on 6/1/16, 6/8/16, 6/13/16, 6/15/16, and 6/20/16. Notation on the back of the MAR indicated the medication was administered for pain. Documentation of the severity of pain Resident #5 was experiencing prior to administration of the medication could not be found in his medical record. Results of the medication administration were documented as "helpful."<br><br>-Oxycodone 20 mg was administered to Resident #5 on 6/7/16. Notation on the back of the MAR indicated the medication was administered for pain. Documentation of the severity of pain Resident #5 was experiencing prior to administration of the medication could not be found in his medical record. Results of the medication administration were documented as "helpful."<br><br>-The "Resident Checked for Pain Q4HR (every four hours) and PRN" section of the MAR was initialed three times daily by nursing staff in 6/2016. No indication of pain level related to these checks could be found in Resident #5's medical record.<br><br>During an interview with RN #1 on 6/22/16 at 9:45 am, she stated since there was no specification on Resident #5's MAR about which pain medication/dose to choose when he was | F 309 | orders have defined parameters detailing based on pain rating, when to administer which medication and at which dose and licensed nurse compliance with use of Universal Pain Assessment Tool. These audits will occur weekly for four weeks then every other week for two months. Any compliance issues identified will be addressed immediately with the appropriate IDT member for corrective action. The findings of these audits will be reported to the Performance Improvement committee beginning with the next scheduled meeting and will continue to be reported for a minimum of three months. After three months, the Performance Improvement committee will review, and may adjust, the frequency of monitoring as it deems appropriate.<br><br>Beginning the week of 7/24/2016, the DNS or her designee will audit a random sample of residents bowel monitors, in conjunction with their medication administration record, to determine compliance with physician notification of irregular bowel status. These audits will occur bi-weekly for one month then weekly for two months. Any compliance issues identified will be addressed immediately with the appropriate IDT member for corrective action. The findings of these audits will be reported to the PI committee beginning with the next scheduled meeting and will continue to be reported for a minimum of three months. After three months, the Performance Improvement committee will review, and | |

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| F 309 | Continued From page 4<br>experiencing pain, she would just look at his face and decide which medication and how much to give based on his expression. When asked if a pain scale was used to determine Resident #5's pain level prior to administering pain medication, she stated there was not.<br><br>During an interview with RN #2 on 6/22/16 at 4:20 pm, she stated she could tell when Resident #5 was in pain by getting clues from how he was acting and usually just administered Norco (hydrocodone/Acetaminophen 5/325) because that medication seemed to have a longer effect in reducing his pain. She stated she knew a pain scale existed for measuring pain level, but that the facility did not use one.<br><br>During an interview with LPN #1 on 6/23/16 at approximately 8:00 am, she stated Resident #5 could tell staff that his pain was "pretty bad" or "real bad" and she decided which pain medication to give him based on that. LPN #1 was not aware of a standard scale used to measure a resident's pain level.<br><br>During an interview with LPN #2 on 6/23/16 at approximately 8:05 am, she stated, some nurses gave a lot of narcotics (oxycodone), however she gave Resident #5 the Norco as it lasted longer.<br><br>During an interview with the DON, on 6/23/16 at approximately 11:45 am, she stated that in reviewing Resident #5's MAR, she could see there was no way for nursing staff to uniformly decide which medication and what dose to give to Resident #5 when he was in pain. She stated there should be an order in place to indicate the amount and type of medication to give based on | F 309 | may adjust, the frequency of monitoring as it deems appropriate. | |

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| F 309 | Continued From page 5<br>a specific level of pain. She stated a "Faces Pain Scale" should be used to determine how much pain Resident #5 was in for routine checks and when he had complaints of pain.<br><br>2. Resident #11's Face Sheet indicated she was admitted to the facility on 1/13/16 with diagnoses including Schizoaffective Disorder and chronic cholecystitis (inflammation of the gallbladder).<br><br>Resident #11's 4/21/16 quarterly MDS assessment documented she was cognitively intact and had almost constant pain that limited her ability to sleep at night and interfered with normal day-to-day activities.<br><br>Resident #11's Physician's Orders, dated 6/2016, included the following pain management orders:<br><br>-Hydrocodone/Acetaminophen 5/325 (a narcotic pain medication) one tablet by mouth every four hours as needed for pain.<br><br>-Ibuprofen 600 mg twice daily as needed for pain.<br><br>-Tylenol 325 mg by mouth every four hours as needed for pain.<br><br>-Tylenol 650 mg by mouth every four hours as needed for pain.<br><br>-Tylenol 325 mg one tablet by mouth every four hours as needed for pain.<br><br>-Tylenol 325 mg two tablets by mouth every four hours as needed for pain.<br><br>-Check resident for pain every four hours and | F 309 | | |

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| F 309 | Continued From page 6<br>prn.<br><br>Resident #11's MARs for 6/2016 documented the following:<br><br>-Hydrocodone/Acetaminophen 5/325 one tablet was administered to Resident #11 on 6/1/16 (three times), 6/2/16 (four times), 6/3/16 (three times), 6/4/16 (twice), 6/5/16 (twice), 6/6/16, 6/7/16 (four times), 6/8/16 (twice) 6/9/16, 6/10/16 (three times), 6/11/16 (three times), 6/12/16 (twice), 6/13/16 (three times) 6/14/16 (three times), 6/15/16 (twice), 6/16/16 (three times), 6/17/16, 6/18/16 (three times), 6/19/16 (three times), 6/20/16 (three times), and 6/21/16 (twice). Notation on the back of the MAR stated the medication was administered for hip/leg pain. Documentation of the severity of pain Resident #11 was experiencing prior to administration of the medication could not be found in her medical record. Results of the medication administration were documented as "helped or "sleeping."<br><br>-Ibuprofen 600 mg was administered to Resident #11 on 6/12/16. Notation on the back of the MAR indicated the medication was administered for pain. There was no documentation on the MAR regarding the reason the Ibuprofen was administered or if it was effective for Resident #11.<br><br>-Tylenol 325 mg was not administered to Resident #11 in 6/2016.<br><br>-Tylenol 650 mg was administered to Resident #11 on 6/2/16 and 6/4/16. Notation on the back of the MAR indicated the medication was administered for pain. Results of the medication | F 309 | | |

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| F 309 | Continued From page 7<br>administration were documented as "fair."<br><br>-The "Resident Checked for Pain Q4HR (every four hours) and PRN" section of the MAR was initialed three times daily by nursing staff in 6/2016. Documentation of pain level related to the checks was not found in Resident #11's medical record.<br><br>During an interview with LPN #1 on 6/23/16 at approximately 8:00 am, she stated Resident #11 could tell staff what she wanted for pain, and would state, "Give me a Norco" or "Give me ibuprofen." LPN #1 was not aware of a standard scale used to measure a resident's pain level.<br><br>During an interview with LPN #2 on 6/23/16 at approximately 8:05 am, she stated she usually gave the Norco as it lasted longer.<br><br>During an interview with the DON, on 6/23/16 at approximately 11:45 am, she stated that in reviewing Resident #11's MAR, she could see there was no way for nursing staff to uniformly decide which medication and what dose to give to her when she was in pain. She stated there should be an order in place to indicate the amount and type of medication to give based on a specific level of pain. She stated a "1 to 10 Pain Scale" should be used to determine how much pain Resident #11 was in for routine checks and when she had complaints of pain.<br><br>3. Resident #8 was admitted to the facility in 2011 with multiple diagnoses, including multiple sclerosis and osteoarthritis. Hospice care was started on 6/1/16. | F 309 | | |

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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 309 | Continued From page 8<br>Resident #8's significant change MDS assessment, dated 6/7/16, documented she was understood and able to understand others, had modified independence with cognitive skills for daily decision making, required total assistance with toileting, and did not have constipation.<br><br>Resident #8's care plan, printed 4/6/16, included the potential for alteration in patterns of elimination related to decreased mobility/activity, weakness, fatigue, pain, refusal of the bowel protocol, incontinent of bowel, with decrease in oral intake added on 6/20/16. Interventions included to document the size and consistency of BMs, and an 8/3/12 FYI that it was normal for Resident #8 to have bowel movements greater than 6 days apart.<br><br>Resident #8's physician's orders included several pain medications with constipation as a potential adverse reaction. The medications included:<br><br>* Tramadol 50 mg by mouth every 6 hours PRN for pain, started 6/17/15;<br><br>* ibuprofen, 400 mg by mouth every 8 hours PRN for arthritis pain, started 6/17/15;<br><br>* morphine sulfate 5 - 10 mg by mouth 1/2 hour before dressing changes (left foot dressing changes were daily), started 5/20/16. The frequency of the morphine was increased to every 1 hour prn on 6/1/16; and,<br><br>* transdermal fentanyl 12.5 mcg/hour every 3 days, started 3/25/16. The fentanyl was increased to 25 mcg on 4/19/16, to 50 mcg on 5/2/16, and to 75 mcg on 6/17/16 related to | F 309 | | |

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|---|---|---|---|
| | 135055 | | 06/23/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| VALLEY VISTA CARE CENTER OF SANDPOINT | 220 SOUTH DIVISION<br>SANDPOINT, ID 83864 |

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| F 309 | Continued From page 9<br>increased complaint of pain.<br><br>A 5/28/16 fax communication to the physician documented, "Resident has no recorded BM in 14 days." On 6/1/16, the physician ordered, "Follow bowel protocol if tolerated..." and on 6/22/16 the physician ordered, "DC bowel protocol - terminal/comfort care".<br><br>Resident #8's Resident Care Guidelines documented no BM for 16 days in April 2016, from 4/15 through 4/30, and for 12 days in May 2016, from 5/15 through 5/26.<br><br>IDPNs, dated 12/8/15 through 6/22/16, did not include documentation that the physician was notified when Resident #8 did not have a BM for more than 4 to 6 days in April and May 2016.<br><br>On 6/22/16 at 9:30 am, LPN #3 said the facility bowel protocol was discontinued shortly after Resident #8 was admitted because her normal pattern was a BM every 4 to 6 days. LPN #3 added that in 2014 the physician documented the BMs were up to 8 days apart without problems. The LPN said the facility bowel protocol was not restarted until 6/1/16 when hospice discovered Resident #8 had not had a BM for 14 days.<br><br>On 6/23/16 at 8:55 am, LPN #3 said she had reviewed Resident #8's MARs for April and May 2016 and that no bowel medications were given because none were ordered. | F 309 | | |
| F 428<br>SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed | F 428 | | 7/27/16 |

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| F 428 | Continued From page 10<br>pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, it was determined the facility failed to act upon irregularities identified by a pharmacist during monthly medication regimen reviews (MRRs) for 1 of 9 sample residents (#8) whose medication were reviewed. The failure created the potential for Resident #8 to experience adverse reactions due to unnecessary medications. Findings include:<br><br>Resident #8 was admitted to the facility in 2011, with multiple diagnoses including multiple sclerosis, hypothyroidism, seizure disorder, and osteoarthritis. Hospice care was started on 6/1/16.<br><br>The June 2016 Physician Order Report documented Resident #8's daily thyroid hormone, levothyroxine, was started in 2011, Keppra twice a day was started in 2012 for seizure disorder, and Tramadol PRN for pain was started 6/17/15.<br><br>Resident #8's 11/17/15 MRR recommended a thyroid panel related to the use of levothyroxine and documented that one was not found in the chart. The pharmacist also recommended a CMP | F 428 | Corrective action:<br><br>Resident #8's attending physician acknowledged the consultant pharmacist's recommendation on 4/20/2016 stating, "I disagree. Comfort care only.". There is no further corrective action to take for this resident.<br><br>Other residents:<br><br>All residents have the potential to be affected by the deficient practice of physician's lack of response to consultant pharmacist's recommendation. An audit of all current consultant pharmacist's recommendations will be completed by 7/22/2016. Any recommendations not responded to by attending physician will be resent for response.<br><br>Facility systems: | |

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| F 428 | Continued From page 11<br>or renal panel related to the use of Keppra.<br><br>Resident #8's 12/5/15 MRR questioned the use of Tramadol because it can precipitate seizures.<br><br>The MRRs, dated 1/13/16 and 2/18/16, documented no response to the recommendations made in November and December 2015.<br><br>The 3/22/16 MRR documented a letter regarding the November and December 2015 recommendations was resent.<br><br>On 6/22/16 at 5:30 pm, the DON said she prompted Resident #8's physician repeatedly to address the MRR recommendations but the physician did not respond until March 2016 and did not address the concerns then. The DON provided the 3/22/16 pharmacist's letter to the physician which documented "...issues were sent...in November and December 2015, but no response could be found in the chart..." The physician's response, dated 4/20/16, documented "I disagree" and "Comfort care only".<br><br>After hospice care was started on 6/1/16, Resident #8's levothyroxine and Tramadol were discontinued on 6/2/16 and Keppra was discontinued on 6/9/16. | F 428 | Beginning 7/22/2016, all consulting pharmacist recommendations will be copied and stored by medical records staff. As each recommendation is responded to by the physician, medical records staff will destroy unsigned copy. Any remaining unacknowledged recommendations will be forwarded to the DNS for re-submission to the MD weekly.<br><br>Monitoring:<br><br>Beginning the week of 7/24/2016, the DNS or her designee will complete a tracking form to identify physicians consistently not responding to the consulting pharmacist's recommendations. This tracking form will be updated weekly for four weeks then bi-weekly for two months. Those physician's found to be out of compliance with this regulation will be discussed with the facility's medical director at the weekly resident at risk meeting, beginning at the next scheduled meeting. The medical Director, in conjunction with the clinical administration team, will determine an effective method for re-educating the offending physicians. After three months, the clinical administration team as well as the medical director will review, and may adjust, the frequency of monitoring. | |

Bureau of Facility Standards

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| | **MDS001540** | | **06/23/2016** |

NAME OF PROVIDER OR SUPPLIER
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STREET ADDRESS, CITY, STATE, ZIP CODE
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| C 000 | 16.03.02 INITIAL COMMENTS<br><br>The following deficiencies were cited during the state licensure survey between 6/20/16 and 6/23/16.<br><br>The team members conducting the survey were:<br><br>Linda Kelly, RN, Team Coordinator<br><br>Abbreviation:<br>DON = Director of Nursing | C 000 | | |
| C 409 | 02.120,05,i Required Room Closet Space<br><br>i. Closet space in each sleeping room shall be twenty inches by twenty-two inches (20" x 22") per patient/resident. Common closets utilized by two (2) or more patients/residents shall be provided with substantial dividers for separation of each patient's/resident's clothing for prevention of cross contamination. All closets shall be equipped with doors. Freestanding closets shall be deducted from the square footage in the sleeping room.<br>This Rule is not met as evidenced by:<br>Based on resident and staff interview and a waiver in effect, it was determined the facility failed to ensure the required personal closet space for residents in rooms 102, 108, and 304. The small closets created the potential for residents to have insufficient space for storing clothing and personal items. Findings include:<br><br>On 6/22/16 at 4:50 pm, the resident in room 304 said the closet was adequate. | C 409 | Requested continuation of waiver | 7/20/16 |

Bureau of Facility Standards

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 07/21/16 |

Bureau of Facility Standards

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| | **MDS001540** | | **06/23/2016** |

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| C 409 | Continued From page 1<br><br>On 6/22/16 at 5:00 pm, the DON requested continuation of the waiver for the less than required closet space for resident rooms 102, 108, and 304. | C 409 | | |
| C 422 | 02.120,05,p,vii Capacity Requirments for Toilets/Bath Areas<br><br>vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water.<br><br>This Rule is not met as evidenced by:<br>Based on interview and a waiver in effect, it was determined the facility failed to ensure there was 1 tub or shower for every 12 licensed beds. The failure had the potential for a negative effect for all residents living in the facility. Findings include:<br><br>The facility, licensed for 73 beds, was required to have 7 tubs or showers available for resident use. The facility had 5 bathing facilities.<br><br>On 6/21/16 at 3:00 pm, a Group Interview was conducted with 9 residents who denied concerns or issues about insufficient bathing facilities.<br><br>On 6/22/16, the DON requested a continuation of the waiver for the required number of tubs or showers. | C 422 | Requested continuation of waiver. | 7/20/16 |

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

December 9, 2016

Jeri Herrera, Administrator
Valley Vista Care Center of Sandpoint
220 South Division
Sandpoint, ID 83864-1759

Provider #: 135055

Dear Ms. Herrera:

On **June 23, 2016**, an unannounced on-site complaint survey was conducted at Valley Vista Care Center of Sandpoint. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007162**

Allegation #1:

Staff responses to call lights were up to forty-five minutes long for two identified residents.

FINDINGS:

The complaint was investigated in conjunction with the federal recertification survey conducted June 20, 2016 through June 23, 2016.

An initial tour of the facility was conducted immediately after the survey team entered the building. Residents in general were observed for grooming and staff responses to call lights were observed daily throughout the survey.

The clinical records of fifteen residents, including the two identified residents, were reviewed for

quality of life and quality of care issues. The facility's staffing schedules and records for the three week period preceeding the survey and for August 2015 were reviewed. The facility's grievance files for May 2015 through June 23, 2016 were also reviewed.

Interviews were conducted with three individual residents, two resident's family member, and nine residents in a Resident Group Interview with two surveyors. Several Licensed Nurses, Certified Nursing Assistants and the Director of Nursing were also interviewed.

Resident call lights were observed being answered in ten minutes or less and none of the interviewed residents, family, or staff voiced concerns about slow call light response times. In addition, there were no documented concerns about slow call lights response times, and the facility exceeded the minimum state requirement for nursing staff.

The allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

An identified resident's hair was too long.

FINDINGS:

There were no observations of unkept hair for general resident population during the survey and there were voiced or written concerns about hair that was too long. The identified resident said "No" when asked if his/her hair was too long.

The allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility wanted to separate two identified residents living in the same room because they said they were too loud, had increase in aggressive behaviors, frequently used the call light and the behavior had been going on for months; but, the physician said the residents did not need to be moved.

FINDINGS:

The clinical records documented the facility did discuss moving and separating the two identified residents with their representatives and offered options on how to accomplish it. However, the representatives refused and the residents were not moved or separated.

The allegation was substantiated; however, the facility acted appropriately and deficient practice was not identified.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #4:

A facility nurse said that two identified residents in the same room use the call light twenty to thirty times a night, mostly for one of them to use the bedpan. The Reporting Party asked if the resident who needed the bedpan had been tested for a urinary tract infection and provided a phone number but was not called back.

FINDINGS:

Staff interviews and review of Occurence Reports confirmed the two identified residents did activate their call lights repeatedly and that staff responded approriately.

The clinical record documented the resident who used a bedpan refused for the three days to urinate in a toilet with a urine collection device in it. However, a urine sample obtained after the three days of refusals was negative for urinary tract infection.

The allegation was substantiated; however, deficient practice was not identified.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #5:

The only recent care plan update for one identified resident was for 'dementia, physical and verbal aggression, resistance to care and yelling out.' Another identified resident's care plan had not been updated.

FINDINGS:

Review of care plans for fifteen residents, including those of the two identified residents, revealed the care plans were routinely reviewed and appropriately updated or revised when necessary. In addition, there were multiple observations of care planned interventions being implemented.

Deficient practice was not identified and the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Two of the allegations were substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Nina Sanderson, L.S.W., Supervisor
Long Term Care

NS/lj