



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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February 13, 2017

Bradley Hruza, Administrator
Valley Vista Care Center of St Maries
820 Elm Street
St Maries, ID 83861-2119

Provider #: 135075

Dear Mr. Hruza:

On February 8, 2017, an on-site revisit of your facility was conducted to verify correction of deficiencies noted during the survey of December 5, 2016. Valley Vista Care Center of St Maries was found to be in substantial compliance with federal health care requirements regulations as of February 8, 2017.

Thank you for the courtesies extended to us during our on-site revisit. If you have any questions, comments or concerns, please contact David Scott, RN, or Nina Sanderson, LSW, Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards

DR/lj



I D A H O D E P A R T M E N T O F
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March 17, 2017

Bradley Hruza, Administrator
Valley Vista Care Center of St Maries
820 Elm Street
St Maries, ID 83861-2119

Provider #: 135075

Dear Mr. Hruza:

On **February 8, 2017**, an unannounced on-site complaint survey was conducted at Valley Vista Care Center of St Maries. The Complaint was investigated during a Complaint and Follow-up Investigation Survey conducted February 6, 2017 to February 8, 2017.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007460

ALLEGATION #1:

The facility did not turn the identified resident every two hours per physician orders for pressure sore issues.

FINDINGS:

Immediately after entering the facility on the first day of the survey, the survey team conducted a general tour of residents' rooms and common areas observing for overall cleanliness, odors, and equipment storage. Throughout the survey, eight individual residents and all residents in general were observed for residents' rights, abuse and neglect, quality of care and misappropriation of property. Throughout the survey, the potential for, or allegations/incidents of abuse and staffing were investigated. In addition, facility staff was observed as they provided cares, interacted with residents and responded to residents' needs, call lights, and any other requests.

The clinical records of the identified resident and seven other residents were reviewed for residents' rights, quality of care, abuse, neglect, and misappropriation of residents' belongings. The facility's grievance files, Incident and Accident reports, and reportables were reviewed.

Interviews were conducted with multiple individual residents, including the identified resident. Several direct care staff, including nurses and nursing aides, were also interviewed as well as the Director of Nursing Services, Social Worker and the Administrator. The interviews included questions about abuse, staffing, neglect, resident property, call lights, pressure sore practices, and resident right- and care issues.

Based on interviews with staff and record reviews, there were no concerns with staff not turning the identified resident when the identified resident would allow it.

The identified resident was observed in a wheelchair for more than two hours at a time as staff whether she wanted to lie down and the resident declined. The staff respected the identified resident's wishes.

The clinical record documented the identified resident refused positioning and moving fourteen times between January 19, 2017 and February 7, 2017. The identified resident's clinical records contained a physician's note dated February 2, 2017 which documented the wound was healing. The note documented the resident told the doctor she was up in her chair for only two hours a day, however staff documented she was in her chair for eight hours a day and the resident was observed in her wheelchair for extended periods of time in excess of two hours daily throughout survey.

Based on observations, interviews, and record reviews, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #2:

The identified resident's call light was out of reach.

FINDINGS:

Numerous observations were made throughout the facility. Interviews were conducted with multiple residents and numerous medical records were reviewed. Other residents did not voice any concerns of call bells being out of their reach.

The identified resident was observed throughout the survey using her call light and staff answering the call light in a timely manner. On February 7, 2017 at 3:41 pm, the identified resident was observed in her wheelchair as she came out of her room, wheeled to the nurses station, and asked an aide to move her call light to the right side of her bed. The aide went into the room and moved the call light for the resident.

Based on observations and interviews, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #3:

The identified resident fears weekend staff includes a certified nursing aide who will cuss at her.

ALLEGATION #4:

The identified resident was missing items from her room.

FINDINGS:

Numerous observations, interviews, and medical records were reviewed for misappropriation of residents' belonging. Other residents, when questioned, did not voice any concerns about missing items not being replaced. Residents stated the facility attempted to locate and/or replace missing items. There were no written Grievances related to missing items filed with the facility from January 19, 2017 to February 7, 2017.

A full abuse task was completed at the facility in which staff members on various shifts, including weekends, correctly explained how to identify, report, investigate, and protect residents from abuse, which included misappropriation of residents' property. No issues were identified.

The identified resident was interviewed about missing items and stated no items had recently gone missing. The identified resident stated items had gone missing in the past, however the resident could not specify when they had gone missing.

Based on observation, interviews, and record review, the allegation could not be substantiated.

Bradley Hruza, Administrator
March 17, 2017
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CONCLUSIONS:

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, R.N., Supervisor
Long Term Care

DS/lj