IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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3232 Elder Street
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Boise, Idaho 83720-0009
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August 18, 2017

Mary Ruth Butler, Administrator
Kindred Nursing And Rehabilitation-- Mountain Valley
601 West Cameron Avenue
Kellogg, ID 83837-2004

Provider #: 135065

Dear Ms. Butler:

On **August 10, 2017**, a survey was conducted at Kindred Nursing and Rehabilitation-- Mountain Valley 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 a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. 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 **August 28, 2017**. Failure to submit an acceptable PoC by **August 28, 2017**, may result in the imposition of penalties by **September 22, 2017**.

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 **September 14, 2017 (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 **November 8, 2017**. A change in the seriousness of the deficiencies on **September 24, 2017**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 8, 2017** includes the following:

Denial of payment for new admissions effective **November 8, 2017**. [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 **February 6, 2018**, 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 **November 8, 2017** 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 **August 28, 2017**. If your request for informal dispute resolution is received after **August 28, 2017**, 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, L.S.W., 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
	135065		08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VALLEY OF CASCADIA	601 WEST CAMERON AVENUE KELLOGG, ID 83837

(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 conducted August 7, 2017 to August 10, 2017. The surveyors conducting the survey were: Jenny Walker, RN, Team Coordinator Sheila Sizemore, RN Haley Young, LSW ABBREVIATIONS: CNA = Certified Nursing Assistant DM = Dietary Manager DON = Director of Nursing MDS = Minimum Data Set RN = Registered Nurse	F 000		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		9/14/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/24/2017

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 278	Continued From page 1 (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to accurately complete an admission Minimum Data Set (MDS) assessment to reflect the resident's current weight status for 1 of 15 sampled residents (Resident #5). The deficient practice created the potential for harm if care plan decisions were made based on inaccurate information. Findings include: Findings include: Resident #5 was readmitted to the facility on 6/30/17 with diagnoses including hypertension and non-Alzheimer's dementia. On 7/3/17, Resident #5's weight list documented a weight of 150.4 pounds. On 7/10/17, the weight list documented a weight of 147 pounds.	F 278	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Health & Rehabilitation – Mountain Valley does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. F278 Resident Specific	

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F 278	Continued From page 2 Resident #5's Admission MDS assessment, dated 7/9/17, documented a weight of 147 pounds. On 8/8/17 at 3:30 p.m., the MDS Coordinator stated the Dietary Manager should not have used the weight of 147 for the admission MDS assessment, as the weight of 147 pounds was taken after the MDS date. On 8/8/17 at 3:40 p.m., the Dietary Manager stated the weight she had used to complete Resident #5's MDS was taken after the MDS assessment date, and she should not have used that weight.	F 278	The clinical management team reviewed resident #5 and completed a modified admission MDS to reflect correct weight within the assessment reference period. Other Residents The clinical management team reviewed other resident's admission MDS' to validate weights were used within the assessment reference period to complete the MDS. No additional modifications were indicated. Facility Systems Staff that complete admission MDS' are educated to accuracy in coding upon hire and prior to completion of the MDS. Re-education was provided by the Registered Dietician (RD) and/or Case Manager to include but not limited to, selection of a weight within the assessment reference period for MDS completion. The system is amended to include periodic review of MDS coding accuracy by the case management team. Monitor The Certified Dietary Manager and/or designee will audit admission MDS' for accuracy in weight selection dates weekly for 4 weeks, then once per week for 8 weeks. Starting the week of August 28, 2017, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of	

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F 278	Continued From page 3	F 278	the monitoring after 8 weeks, as it deems appropriate. Date of Compliance September 14, 2017	
F 360 SS=D	483.60 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents received snacks to meet their nutritional needs and food preferences. This was true for 1 of 15 sampled residents (#1). The deficient practice created the potential for harm if the resident experienced weight loss or hunger. Findings include: Resident #1 was admitted to the facility on 5/11/15 with diagnoses which included Type II diabetes and Alzheimer's disease. Resident #1's most recent MDS (Minimum Data Set), dated 6/30/17, documented Resident #1 was able to feed herself and had severely impaired cognition. Resident # 1's care plan, revised on 7/17/16, documented the resident was at risk of nutritional decline with a recent hospitalization which resulted in a decline in her weight. The care plan documented the Dietary Manager would place	F 360	F360 Resident Specific The clinical management team reviewed resident #1 and adjusted her nutritional care plan to support her current nutritional needs including the delivery of snacks by direct care staff. Other Residents The clinical management team reviewed other resident□s nutritional care plans utilizing between meal snacks for plan implementation. Adjustments have been made as indicated. Facility Systems Staff that develop nutritional care plans are educated on the process to include between meal interventions. Re-education was provided by the RD and/or Staff Development Coordinator (SDC) to include but not limited to, the	9/14/17

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F 360	Continued From page 4 snack items of preference at Resident #1's bedside. On 8/7/17 at 1:55 pm and 3:45 pm, Resident #1's bedside table was next to the resident's bed, but pushed back far behind the head of the bed. No snacks were visible in the room. On 8/8/17 at 10:27 am, 11:55 am, and 3:40 pm, Resident #1 was in bed sleeping. The bedside table was pushed far behind the head of the bed with no snacks visible. On 8/9/17 at 9:50 am, Resident #1 was in bed sleeping. No snacks were visible in the room. On 8/9/17 at 11:00 am, there was a basket on Resident #1's bedside table with a box of Kleenex in it. There was a snack cake and a granola bar under the Kleenex, which could not be seen unless the Kleenex was moved. On 8/10/17 at 10:45 am, there were no snacks visible in Resident #1's room. On 8/10/17 at 10:50 am, CNA #1 stated the staff offered Resident #1 snacks whenever the snack cart came around throughout the day. CNA #1 stated Resident #1 did not have snacks in her room and was not allowed to keep snacks in her room. On 8/10/17 at 10:55 am, RN #1 stated she was unsure if Resident #1 had snacks in her room, and did not know if she was supposed to have them in her room. On 8/10/17 at 11:15 am, the Dietary Manager	F 360	process of validating nutritional care plans are implemented at the bedside and/or adjustment with clinical changes. Monitor The Certified Dietary Manager and/or designee will audit between meal nutritional interventions for implementation three times per week for 4 weeks, then twice per week for 4 weeks, then once per week for 4 weeks. Starting the week of August 28, 2017, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Compliance September 14, 2017	

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F 360	Continued From page 5 stated there was a basket in Resident #1's room which was stocked with snacks every Monday and Friday. The Dietary Manager stated she had not had a chance to stock the basket that Monday. The Dietary Manager stated that due to Resident #1's cognitive impairment snacks would need to be in "plain sight" so the resident would be more likely to eat them. The Dietary Manager stated that Resident #1 had a history of weight loss, and snacks in her room were an intervention to ensure she had no further weight loss. On 8/10/17 at 3:15 pm, the Director of Nursing (DON) stated Resident #1's nutritional care plan should be followed, and snacks should be visible at bedside so the resident can take a snack if she chooses.	F 360		
F 371 SS=C	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 371		9/14/17

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F 371	Continued From page 6 (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure food was prepared and served under sanitary conditions for all 63 residents in the facility who received food from the kitchen when hairnets worn by the dietary staff did not fully restrain their hair. The deficient practice created the potential for residents to experience a loss of appetite if their meal was contaminated by staff hair. Findings include: Record review of the facility's policy titled, "Personal Hygiene and Handling Food", dated 5/28/2016, indicated "...hair restraints such as hats, hair coverings or nets, and beard restraints are worn at all times when in the kitchen. This applies to food service personnel, as well as, maintenance personnel and inspectors. Hair is to be fully contained inside the covering." On 8/7/17 at 10:50 a.m., the Dietary Manager (DM) and Cook #2 were working in the kitchen without hair fully secured in their hair nets. Hair was hanging out of the hair nets around their ears and the backs of their necks. On 8/8/17 at 1:15 p.m., the DM and Cook #4 were working in the kitchen. They were wearing	F 371	F371 Resident Specific The interdisciplinary team reviewed the process and current hair net used in dietary. A change in hair restraint style has been implemented which more fully contains staff hair. Other Residents Upon rounds by the interdisciplinary team, the new hair restraints are noted to fully contain staff hair. Facility Systems Dietary Staff are educated to personal hygiene and handling of food upon hire. Re-education was provided by RD to include but not limited to, the process of fully securing hair with the new style of hair restraint. The system is amended to include the new style of hair restraint and staff to staff accountability to maintain hair restraints. Monitor The Certified Dietary Manager and/or designee will audit correct application of	

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F 371	Continued From page 7 hair nets that did not fully secure their hair. On 8/9/17 at 8:55 a.m., Cook #2 and the Assistant Dietary Manager were working in the kitchen, wearing hair nets that did not fully secure their hair. There were fly away hairs hanging from the sides and back of their hairnets. On 8/9/17 at 11:35 a.m.,during the meal service, Cook #1, Cook #2, Cook #3, the Assistant Dietary Manager and the DM, were wearing hair nets that did not fully contain their hair to prevent potential food contamination. Cook #1 and the Assistant DM had their hair pulled up in high buns and the hair net did not reach the bottom of their hairline. There was approximately 3 inches of their hair exposed in the back. Cook #2, Cook #3 and the DM had hair hanging out of the hairnet around their ears and in the back around the neck. On 8/10/17 at 8:55 a.m., the DM said all the dietary staff should have their hair fully secured in their hair nets. She said she was aware the staff had issues with keeping the hair nets covering their hair completely. The DM said no steps had been taken to address this problem.	F 371	hair restraint to validate hair is fully restrained 3 times weekly on various shifts, for 12 weeks starting the week of August 28, 2017, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 7 weeks, as it deems appropriate. Date of Compliance September 14, 2017	