



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSS BARRON – 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
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December 21, 2018

Mary Ruth Butler, Administrator
Mountain Valley Of Cascadia
601 West Cameron Avenue
Kellogg, ID 83837-2004

Provider #: 135065

Dear Ms. Butler:

On **December 13, 2018**, a survey was conducted at Mountain Valley of Cascadia 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.

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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 **December 31, 2018**. Failure to submit an acceptable PoC by **December 31, 2018**, may result in the imposition of penalties by **January 23, 2019**.

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 **January 17, 2019 (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 **March 13, 2019**. A change in the seriousness of the deficiencies on **January 27, 2019**, 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 **March 13, 2019** includes the following:

Denial of payment for new admissions effective **March 13, 2019**. [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 **June 13, 2019**, 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 Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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 **March 13, 2019** 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 **December 31, 2018**. If your request for informal dispute resolution is received after **December 31, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,

A handwritten signature in black ink that reads "Debby Ransom". The signature is written in a cursive style and is positioned above the typed name and title.

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

dr/lj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/13/2018
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VALLEY OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 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 and complaint survey conducted December 10, 2018 to December 13, 2018. The surveyors conducting the survey were: Teresa Kobza, RDN, LD, Team Coordinator Brad Perry, LSW Ann Monhollen, RN Abbreviations: DNS = Director of Nursing Services MAR = Medication Administration Record MDS = Minimum Data Set mg = Milligram PRN = as needed	F 000			
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure residents were assessed to determine if they were safe to self-administer medications. This was true for 2 of 2 residents (#28 and #29) reviewed for self-administration of medications. The failure created the potential for adverse effects if Resident #28 and Resident #29 self-administered medications inappropriately. Findings include:	F 554	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Mountain Valley of Cascadia 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	12/31/18	

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

TITLE

(X6) DATE

Electronically Signed

12/31/2018

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 554	<p>Continued From page 1</p> <p>The facility's policy titled, "Self-Administration of Medications", initiated on 11/28/17, documented the interdisciplinary team determined if a resident was safe to self-administer medications, and the facility would periodically re-evaluate residents to determine if they were still able to self-administer medications safely.</p> <p>1. Resident #28 was admitted to the facility on 7/8/18, with diagnoses which included atrial fibrillation (rapid, irregular heart beat), cerebrovascular accident (CVA) with aphasia (difficulty speaking) and hypertension.</p> <p>An MDS assessment, dated 10/14/18, documented Resident #28 had moderate cognitive impairment.</p> <p>A physician's order, dated 11/1/18, documented Resident #28 received Coumadin (a blood thinner) 3 mg by mouth on Sunday, Tuesday, Thursday, and Saturday.</p> <p>On 12/11/18 at 3:45 PM, Licensed Practical Nurse (LPN) #1 was observed placing a medication cup on Resident #28's nightstand and leaving the room. LPN #1 stated Resident #28 did not want staff to watch him take his medications. LPN #1 stated she checked on Resident #28 to ensure he took the medication.</p> <p>On 12/11/18 at 3:55 PM, LPN #1 stated she was not aware if Resident #28 has been assessed to safely self-administer his medications.</p> <p>Resident #28's clinical record did not contain a self-administration assessment until 12/11/18 at</p>	F 554	<p>proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>F554</p> <p>Resident Specific The clinical management team reviewed resident #28 and #29. A self-administration assessment was completed for resident #28 and for resident #29 on 12/11/18 with both determined to be safe for self-administration of medications. The physician orders, care plan, and monitoring have all been updated as indicated.</p> <p>Other Residents The clinical management team reviewed other residents for self-administration of medication. Adjustments have been made as indicated.</p> <p>Facility Systems Licensed nurses will be educated on the Eight Rights of Medication Administration and Self Administration of Medication Policies and Procedures. Re-education was provided by Chief Nursing Officer and Staff Development Coordinator to include but not limited to, self-administration of medication evaluation, consent, order, care plan updates, monitoring, and identification of current and/or previous self-administration of medication</p>		

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F 554	<p>Continued From page 2 3:57 PM, after the medication observation pass.</p> <p>On 12/12/18 at 12:30 PM, the DNS stated Resident #28 did not have a self-administration assessment prior to the medication pass observation on 12/11/18.</p> <p>2. Resident #29 was readmitted to the facility on 5/8/16, with diagnoses which included diabetes mellitus, hypertension, chronic pain, arthritis, and vitamin D deficiency.</p> <p>An annual MDS assessment, dated 10/14/18, documented Resident #29 was cognitively intact.</p> <p>The care plan area addressing Resident #29's self-administration ability, reinitiated 12/11/18, documented she expressed the desire and was assessed to be safe with self-administering medications. The care plan for self-administration was not active in Resident #29's record until 12/11/18.</p> <p>Resident #29's Physicians Orders included the following:</p> <ul style="list-style-type: none"> - Cardedilol 6.25 mg tablet two times a day for hypertension, ordered 3/26/18. - Oxybutynin Chloride 2.5 mg tablet twice daily for bladder spasms, ordered 5/8/16. - Resident #29's medications could be administered in applesauce, ordered 5/9/16. - Resident #29's medications could be crushed as indicated by pharmacy, ordered 5/9/16. - Resident #29 was assessed to safely self-administer her medications without a nurse present, ordered 12/12/18. 	F 554	<p>evaluations. The system has been amended to include oversight from Chief Nursing Office during clinical meeting and senior leader rounding.</p> <p>Monitor The Chief Nursing Officer and/or designee will audit medication pass for self medication administration twice per week for 4 weeks, then weekly for 8 weeks to validate no medications are left at the bedside without self-administration evaluation completed. Starting the week of January 14, 2019, the review will be documented on the PI 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. Chief Executive Officer will review all tools during clinical meeting.</p> <p>Date of Compliance January 17, 2019</p>		

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F 554	<p>Continued From page 3</p> <p>Resident #29's 12/1/18 -12/12/18 MAR, documented she was provided her scheduled and PRN medications per physician's orders.</p> <p>A Self-Administration of Medication Evaluation, dated 2/29/16, documented Resident #29 was fully capable to self-administer her medications. Resident #29's record did not contain a self-administration reassessment between the dates of 2/29/16 and 12/11/18.</p> <p>A Self-Administration of Medication Evaluation, dated 12/11/18, documented Resident #29 was able to, with assistance, self-administer her medications. Resident #29's record did not contain a current self-administration evaluation until 12/11/18.</p> <p>On 12/11/18 from 9:30 AM to 10:34 AM, Resident #29 was observed in bed with a pill cup next to her bed which contained her morning medications crushed in applesauce.</p> <p>On 12/11/18 at 10:42 AM, Resident #29's medications were observed again crushed in applesauce and placed at her bedside. LPN #2 was present during the observation. LPN #2 stated the medications were there from Resident #29's morning medication pass at 8:00 AM. LPN #2 stated Resident #29 did not like having people watch her take her medications, so the staff left her medications by her bed side and stepped away. LPN #2 stated he forgot to go back and check on her this morning to ensure her pills were consumed. LPN #2 stated he was unsure if Resident #29 had an assessment to self-administer her medication or if her care plan included self-administration of medication.</p>	F 554			

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

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F 554	Continued From page 4 On 12/11/18 at 2:17 PM, Registered Nurse (RN) #2 was observed placing Resident #29's afternoon medications at her bed side and leaving the room. RN #2 stated Resident #29 would self-administer her medications on her own terms. RN #2 stated he would check on her in five to ten minutes to ensure she had taken her medications. RN #2 stated he was unsure if she was assessed to safely self-administer medications or if it was care planned. On 12/12/18 at 10:24 AM, the DNS stated Resident #29 had been assessed to safely self-administered medications on 2/29/16. Resident #29 had experienced a decline in 2017 in which the facility determined she was unable to safely self-administer medications. The DNS stated the facility at that time provided Resident #29 with her medications under supervision. The DNS stated Resident #29 had improved from her decline and began self-administering medications again, and a new self-assessment was not completed until 12/11/18 after staff had made her (DNS) aware of the issue.	F 554			
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F 604		1/17/19	

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F 604	<p>Continued From page 5</p> <p>§483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident comments, and record review, it was determined the facility failed to ensure a resident's chair and bed safety alarms were assessed as potential restraints, and determined medically necessary, prior to implementation. This was true for 1 of 2 (Resident #43) residents reviewed for potential restraints. This deficient practice had the potential for harm if the resident experienced physical deterioration due to lack of movement or a psychological decline due to feelings of being restricted in movement. Findings include:</p> <p>Resident #43 was admitted to the facility on 10/11/18, with multiple diagnoses including dementia, delusional disorder, hallucinations, and</p>	F 604	<p>F604</p> <p>Resident Specific The clinical management team reviewed resident #43 and on 12/12/2018 an Interdisciplinary Restraint Assessment was completed for chair and bed alarm to rule out restraint and determined to be medically necessary.</p> <p>Other Residents The clinical management team reviewed other residents with chair and/or bed alarms to rule out restraint and determine if medically necessary. Adjustments have</p>		

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F 604	<p>Continued From page 6 altered mental status.</p> <p>A consent for the use of bed and chair alarms, dated 10/3/18 (eight days prior to admission), documented Resident #43's family signed a consent for the use of the alarms for Resident #43.</p> <p>A 30-day scheduled MDS assessment, dated 11/12/18, documented Resident #43 had severe cognitive impairment and required extensive assistance of one staff member with all cares except for eating and drinking, and did not use a safety alarm.</p> <p>The care plan area addressing Resident #43's fall risk, dated 10/11/18, documented she utilized chair and bed alarms.</p> <p>On 12/10/18 at 1:21 PM, Resident #43 was observed walking around her room and an alarm was sounding in her room. Resident #43 asked if someone was going to answer that because "it was not" for her. A staff member asked her to return to her wheelchair, which she did, and the alarm stopped sounding.</p> <p>Resident #43's clinical record did not include an assessment which identified the medical symptoms, time and duration of the need for the alarms.</p> <p>On 12/12/18 at 9:56 AM, the DNS stated the alarms should be assessed as a potential restraint. The DNS stated Resident #43's alarms alerted staff of when she got out of bed or her chair and they did not prevent her from moving as observed.</p>	F 604	<p>been made as indicated.</p> <p>Facility Systems Licensed Nurses will be educated on current Restraints Policy and Procedures. Re-education was provided by Chief Nursing Officer and Staff Development Coordinator to include but not limited to, all resident chair and bed safety alarms are evaluated as potential restraints and determined if medically necessary prior to implementation. The system has been amended to include oversight by Chief Nursing Officer and IDT to review potential restraint use in clinical meeting which will include evaluation, consent, order, care plan updates, and monitoring after implementation.</p> <p>Monitor The Chief Nursing Officer and/or designee will audit residents with bed and/or chair alarms twice weekly for 4 weeks, then once weekly for 8 weeks to validate evaluation are current. Starting the week of January 14, 2019, the review</p>		

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F 604	Continued From page 7	F 604	will be documented on the PI 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.		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility	F 842	Date of Compliance January 17, 2019	12/31/18	

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F 842	<p>Continued From page 8</p> <p>must maintain medical records on each resident that are-</p> <ul style="list-style-type: none"> (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized <p>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <ul style="list-style-type: none"> (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <ul style="list-style-type: none"> (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches 	F 842			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/13/2018
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VALLEY OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST CAMERON AVENUE KELLOGG, ID 83837		
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F 842	<p>Continued From page 9 legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <ul style="list-style-type: none"> (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure a physician order was followed for 1 of 5 residents (Resident #27) who were reviewed for complete and accurate medical records. This failed practice had the potential to adversely affect residents' health and condition if physician orders were not followed and cares were not provided. Findings include:</p> <p>Resident #27 was readmitted to the facility on 5/29/08, with multiple diagnoses including heart failure and anxiety.</p> <p>A physician's order, dated 7/26/18, documented Resident #27 received Ativan 0.5 mg every 12 hours PRN for anxiety.</p> <p>A pharmacy recommendation, dated 11/13/18, documented Resident #27 received Ativan 0.5 mg every 12 hours PRN for anxiety and the order must have a stop date not to exceed 6 months.</p>	F 842	<p>F842</p> <p>Resident Specific The clinical management team reviewed resident #27 and on 12/12/2018 updated order for Ativan to include stop date on the signed physician order.</p> <p>Other Residents The clinical management team reviewed other residents with PRN orders for psychoactive medications. Adjustments have been made as indicated.</p> <p>Facility Systems Licensed Nurses will be educated on the process of order entry for PRN psychoactive medications to include stop dates. Re-education was provided by Chief Nursing Officer and Staff Development Coordinator to include but not limited to, order entry to include stop</p>		

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F 842	<p>Continued From page 10</p> <p>The recommendation documented the order needed a stop date added.</p> <p>A physician's response, dated 11/14/18, documented Resident #27 was to receive Ativan 0.5 mg every 12 hours PRN for anxiety with a stop date of 6 months from the review.</p> <p>Resident #27's record did not include documentation the physician's order for the Ativan was updated to include the 6 month stop date.</p> <p>On 12/12/18 at 2:29 PM, the DNS stated the nurse on the floor who received the order should have placed a stop date on the order for Ativan.</p>	F 842	<p>date. The system is amended to include oversight of new orders by Chief Nursing Officer or designee in clinical meeting, Behavioral Management Committee monthly, and Psychotropic Medication Committee every other month. Chief Executive Officer will validate monthly pharmacy recommendations are reviewed by IDT and verified stop date are on orders and do not exceed 6 months.</p> <p>Monitor The Chief Nursing Office and/or designee will audit for new PRN psychoatice medication orders to include stop date daily for 2 weeks, then weekly for 8 weeks. Starting the week of January 14, 2019, the review will be documented on the PI 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.</p> <p>Date of Compliance January 17, 2019</p>		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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June 11, 2019

Mary Ruth Butler, Administrator
Mountain Valley of Cascadia
601 West Cameron Avenue
Kellogg, ID 83837-2004

Provider #: 135065

Dear Ms. Butler:

On **December 10, 2018** through **December 13, 2018**, an unannounced on-site complaint survey was conducted at Mountain Valley of Cascadia. The complaint was investigated in conjunction with the annual recertification survey. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007765

ALLEGATION #1:

Facility restrained a resident to administer a shower on the midnight shift.

FINDINGS #1:

During the onsite investigation, there were no residents being restrained during care of showers/baths. Observations were made with residents who were scheduled to receive their shower/bath during the survey period.

During interviews with residents during the investigation, there were no complaints voiced regarding staff treatment during showers or being forced to take their shower/bath.

Mary Ruth Butler, Administrator
June 11, 2019
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In an interview with the Director of Nursing, she stated residents were scheduled for a shower/bath two times a week, on the day or afternoon shift. No residents were scheduled on the midnight shift.

Record review of the facility bathing schedule documented no residents were scheduled to receive a shower/bath on the midnight shift.

During the Resident Council meeting, no concerns were voiced by the residents in regard to showers/baths. Record review of the past six months of resident grievances showed no documentation of concerns about staff treatment during showers/baths or being forced to take a shower/bath.

Due to investigative findings, the allegation was unable to be substantiated.

ALLEGATION #2:

Staff are eating residents' meals, taking food off the tray line, and there is not enough food to accommodate residents.

FINDINGS #2:

During observations of three meal service lines, sufficient quantities of food were prepared and offered to the residents. No dietary staff were observed eating off the residents' meal trays as trays were being prepared.

During an interview with the Dietary Manager and two dietary aides, they stated no kitchen staff had been observed eating off the tray line.

During observations of two different meals in three different dining rooms, residents were being assisted with meals as needed, no facility staff were observed eating off resident trays, alternate items were available and additional food was available if requested.

During interviews with residents during the onsite investigation, no complaints were voiced regarding meal service, amount of food offered or of staff eating food off resident trays. During the Resident Council meeting, no concerns were voiced in regard to dietary staff or food items. Record review of the past six months did not include documentation of concerns regarding dietary staff or food items.

Due to investigative findings, the allegation could not be substantiated.

Mary Ruth Butler, Administrator
June 11, 2019
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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.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in cursive script that reads "Belinda Day".

Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj