



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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TAMARA PRISOCK—ADMINISTRATOR  
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3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
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February 4, 2019

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

Provider #: 135069

Dear Mr. Royeca:

On **January 18, 2019**, a survey was conducted at Bell Mountain Village & Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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 **February 14, 2019**. Failure to submit an acceptable PoC by **February 14, 2019**, may result in the imposition of penalties by **March 9, 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 **February 22, 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 **April 18, 2019**. A change in the seriousness of the deficiencies on **March 4, 2019**, may result in

a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 18, 2019** includes the following:

Denial of payment for new admissions effective **April 18, 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 **July 18, 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 **April 18, 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:

Darwin Royeca, Administrator  
February 4, 2019  
Page 4

<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 **February 14, 2019**. If your request for informal dispute resolution is received after **February 14, 2019**, 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,



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

dr/

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

PRINTED: 02/22/2019  
FORM APPROVED  
OMB NO. 0938-0391

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|--|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                   |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>135069</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>01/18/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BELL MOUNTAIN VILLAGE &amp; CARE CENTER</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>620 NORTH SIXTH STREET<br/>BELLEVUE, ID 83313</b>                   |                      |   |
| (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 investigation survey conducted January 14, 2019 through January 18, 2019.<br><br>The surveyors conducting the survey were:<br><br>Edith Cecil, RN, Team Coordinator<br>Kristy Flodquist, RN<br><br>Abbreviations include:<br>CNA = Certified Nursing Assistant<br>D/C = discontinue<br>DON = Director of Nursing<br>GDR = Gradual Dose Reduction<br>LPN = Licensed Practical Nurse<br>MAR = Medication Administration Record<br>MDS = Minimum Data Set<br>OTC = over the counter<br>RSD = Resident Services Director   | F 000   |   |                      |   |
| F 565<br>SS=E  | Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)<br><br>§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.<br>(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.<br>(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.<br>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written | F 565   |   | 2/26/19              |   |

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

TITLE

(X6) DATE

Electronically Signed

02/13/2019

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 565  | <p>Continued From page 1</p> <p>requests that result from group meetings.</p> <p>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.</p> <p>(A) The facility must be able to demonstrate their response and rationale for such response.</p> <p>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.</p> <p>§483.10(f)(6) The resident has a right to participate in family groups.</p> <p>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on Resident Council meeting minutes, Resident Group interview, policy review, and staff interview, it was determined the facility failed to ensure Resident Council concerns and grievances regarding call light response times were addressed. This was true for 5 of 5 residents (#2, #11, #14, #15, and #26) who attended the Resident Group interview. The deficient practice had the potential to cause psychosocial harm for residents when their concerns were not promptly addressed or acted upon by the facility. Findings include:</p> <p>The Resident Council Meeting minutes, dated 9/17/18, documented under the section for old business, the night shift CNAs were not</p> | F 565   | <p>F 565 Resident/Family Group and Response</p> <p>This facility will ensure Resident Council concerns and grievances regarding call light response times were address. Resident # 2, #11, #14, #15 and #26 were visited by RSD and currently don't have any concerns about call light response. All residents have the potential to be affected by the deficient practice. Staff have been in-serviced on Federal Citation and Deficient Practice. Resident council meeting was held on January 21, 2019. Resident council attendees did not have any concerns about call light response time in this</p> |                      |   |

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| F 565  | <p>Continued From page 2</p> <p>answering the call lights in a timely manner. The minutes documented the action plans were to be developed and the DON was notified of the complaints on 9/18/18. A page attached to the minutes, titled New Business, stated the facility would follow-up with nurses and CNAs, and there was going to be an in-service. The document also stated call lights were better "sometimes."</p> <p>The Resident Council Meeting minutes, dated 10/15/18, did not include documentation about call lights under the sections for old business or new business.</p> <p>The Resident Council Meeting minutes, dated 11/19/18, documented staff were in-serviced and the DON spoke with staff regarding call lights. An attached page, titled Last Meeting Minutes, documented staff were in-serviced about call lights and answering call lights in a timely manner.</p> <p>The Resident Council Meeting minutes, dated 12/17/18, documented CNAs were not answering call lights in a timely manner. In the section of the minutes titled Overview of Progress and Follow-up, it was documented the CNAs were in-serviced.</p> <p>On 1/16/19 at 10:00 AM, a group of five Resident Council members, including the Resident Council president were interviewed. All five residents agreed there were problems with the call lights for the past several months. Some of the call light concerns included staff not answering call lights in a timely manner, times when the call lights were not answered for over an hour, one of the residents was left on the toilet for one and a half</p> | F 565   | <p>meeting.</p> <p>Nursing staff will be re-educated on the importance of answering call lights promptly. Call light response time will be discussed in the monthly Resident Council Meeting until substantial compliance is attained. Negative responses from this meeting will be documented as grievances. Facility grievance investigation and procedure will be implemented to address these concerns. Resident grievances will be presented with a grievance resolution or an answer within 10 business days. Random residents will be interviewed by the Resident Service Director or Designee for any call light response concerns. Responses from the interview will be documented on an interview form. Negative responses from this interview will be documented as grievances. The Facility grievance investigation and procedure policy will be implemented to address any concerns. Residents with grievances will be presented with grievance a resolution or an answer within 10 business days. Audits will be implemented to ensure that all resident grievances are handled accordingly and timely. These audits will be completed weekly x 4, bimonthly x 2, then monthly x 3 by the Resident Service Director. The results of all audits will be presented to the QAA committee for further monitoring and modification based on the findings.</p> |                      |   |

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| F 565  | Continued From page 3<br>hours, and the staff were not leaving the call lights within reach of the residents.<br><br>On 1/17/19 at 5:35 PM, the RSD stated she was the person responsible for the Resident Council Minutes and follow-up. The RSD stated when residents brought up concerns, she went to the department head responsible for the issue, asked the department head to write up what was done, take the response back to the Resident Council, and asked the Council if the response was acceptable. She stated the first meeting she oversaw was on 9/17/18. The RSD stated the old business listed in the minutes was actually new business for the month and the follow-up was an attached page. The RSD did not know the actual date the follow-up was completed. The RSD said the CNAs were in-serviced on call light response times. The RSD confirmed the residents' concerns with call lights were brought up over several months without resolution. She said they had a grievance policy and form to fill out but the residents did not use it for concerns brought forward by the Resident Council. The RSD confirmed there was no documented evidence of call light records, monitoring call light response times, or interviewing staff and residents privately about call lights.<br><br>The RSD provided documentation of a group in-service, dated 9/21/18, which documented the staff received training for call lights to be answered in an appropriate and timely manner. The RSD confirmed this was the only in-service for staff about call lights since 9/17/18, and there were no further in-services after 9/21/18. | F 565   |   |                      |   |
| F 656<br>SS=D  | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)  | F 656   |   | 2/26/19              |   |

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| F 656  | Continued From page 4<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv) In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care | F 656   |   |                      |   |

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| F 656  | <p>Continued From page 5</p> <p>plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to develop and implement comprehensive resident-centered care plans related to the use of psychotropic medications and medical equipment. This was true for 2 of 12 residents (#12 and #21) who were reviewed for care plans. This failure created the potential for harm if residents received medications that may result in negative outcomes without clear indication of need or monitoring and the potential for an increased risk of skin breakdown from improper use of specialized equipment. Findings include:</p> <p>The facility's policy for care plans, revised December 2016, documented comprehensive person-centered care plans included the following:</p> <ul style="list-style-type: none"> <li>* Measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs and was developed and implemented for each resident</li> <li>* When possible, interventions addressed the underlying source of the problem area, and did not just address only symptoms or triggers</li> <li>* Incorporated risk factors associated with identified problems</li> <li>* Identified problem areas and their cause</li> <li>* Developed interventions which were targeted and meaningful to the resident</li> </ul> <p>1. Resident #12 was admitted to the facility on</p> | F 656   | <p>F 656 Develop/Implement Comprehensive Care Plan</p> <p>This facility will ensure to develop and implement comprehensive resident-centered care plans related to the use of psychotropic medications and medical equipment.</p> <p>Resident # 12 Seroquel 50 mg medication was discontinued on 11/16/2018.</p> <p>Resident's Care plan was reviewed and updated to indicate the resident current condition.</p> <p>Dycem (a non-slip mat) is now underneath and on top of the wheelchair cushion in Resident#21's wheelchair for safety.</p> <p>Care plan for Resident # 21 has been reviewed and updated to indicate the resident's current condition and resident's current intervention as order by Resident's Physician.</p> <p>Staff has been educated about the importance of following the Physician's Order and Resident's care plan and the importance of placing Dycem (a non-slip mat) underneath and on top of the wheelchair cushion in Resident#21's wheelchair for safety.</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>Staff have been in-serviced on Federal Citation and Deficient Practice.</p> <p>Staff has been educated about the</p> |                      |   |

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| F 656  | <p>Continued From page 6</p> <p>11/2/18, with a diagnosis of unspecified dementia with behavioral disturbance.</p> <p>A physician's order, dated 11/2/18, documented Resident #12 was to receive Seroquel (antipsychotic) 50 mg by mouth at bedtime for insomnia related to unspecified dementia with behavioral disturbance.</p> <p>A physician's order, dated 11/30/18, documented Resident #12 was to receive Seroquel 50 mg by mouth at bedtime for unspecified dementia with behavioral disturbance. The order did not include insomnia as an indication for the medication.</p> <p>An admission MDS assessment, dated 11/13/18, documented Resident #12:</p> <ul style="list-style-type: none"> <li>* Was severely impaired cognitively</li> <li>* Did not have hallucinations or delusions</li> <li>* Did not exhibit physical or verbal behavioral symptoms directed at others</li> <li>* Did not exhibit rejection of care</li> <li>* Wandered 1-3 days during the 7-day observation period</li> <li>* Did not intrude on the privacy of others</li> <li>* Did not place himself at a significant risk for danger</li> </ul> <p>The MDS also documented Resident #12 received antipsychotic medication daily.</p> <p>A care plan, dated 11/20/18, documented Resident #12 exhibited wandering related to his dementia diagnosis. The care plan did not include the use of antipsychotic medications. The care plan did not provide specific behaviors for which the antipsychotic medication was</p> | F 656   | <p>importance of following Physician <input type="checkbox"/> Orders and Resident <input type="checkbox"/> care plans. All residents with airbeds and roho cushions have been reviewed and updated to ensure that their resident care plan were accurate per Physician <input type="checkbox"/> orders and resident <input type="checkbox"/>s current condition. Care plan for Residents with Antipsychotics have been reviewed and updated to ensure that residents received antipsychotic medications only when clinically indicated for the treatment of specific conditions, specific target behaviors were identified and monitored, physician-ordered treatments were completed and potential adverse side effects of the medication were monitored. Resident Care plans for preventative equipment will be reviewed and updated per MDS Schedule to ensure that preventative equipment ordered is accurate and in placed per Physician <input type="checkbox"/> Orders. Resident Care plans for antipsychotic medications will be reviewed and updated per MDS Schedule to ensure that residents received antipsychotic medications only when clinically indicated for the treatment of specific conditions, specific target behaviors were identified and monitored, physician-ordered treatments were completed and potential adverse side effects of the medication were monitored . Audits will be completed weekly x 4, bimonthly x 2, then monthly x 3 by the Director of Nursing Services or Designee. The results of all audits will be presented</p> |                      |   |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>BELL MOUNTAIN VILLAGE &amp; CARE CENTER</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>620 NORTH SIXTH STREET<br/>BELLEVUE, ID 83313</b>                   |                      |   |
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| F 656  | <p>Continued From page 7</p> <p>needed or include direction for staff to monitor for specific behaviors, adverse drug reactions, or the effectiveness of the medication.</p> <p>On 1/16/19 at 2:31 PM, the RSD stated Resident #12 was on Seroquel when he came to the facility. She stated she thought he was wandering, had verbal and physical aggression, and was urinating in the trash cans. The RSD stated the care plan did not address the behaviors or his antipsychotic medication.</p> <p>2. Resident #21 was admitted to the facility on 9/8/18, with diagnoses which included dementia, malnutrition, and a Stage IV pressure ulcer (full thickness skin loss with exposed bone, tendon, or muscle).</p> <p>An admission MDS assessment, dated 9/15/18, documented Resident #21 had a Stage IV pressure ulcer present on admission.</p> <p>Resident #21's skin/pressure ulcer care plan, updated on 12/28/18, documented Resident #21 had a pressure ulcer. The interventions included the use of a high-density mattress and a cushion for her wheelchair.</p> <p>A physician's order, dated 10/20/18, directed staff to place dycem (a non-slip mat) underneath and on top of the wheelchair cushion in Resident #21's wheelchair for safety.</p> <p>A physician's order, dated 10/25/18, directed staff to place an air overlay to Resident #21's bed, not a high density mattress, and a Roho cushion (a foam cushion with soft flexible air cells used to decrease pressure on skin) in her wheelchair</p> | F 656   | to the QAA committee for further monitoring and modification based on the findings.                             |                      |   |

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| F 656  | Continued From page 8<br>every shift for skin integrity.<br><br>On 1/17/19 at 9:36 AM, an air mattress overlay was observed on Resident #21's bed and dycem was on top of her wheelchair cushion. The dycem was not underneath the cushion as ordered by her physician.<br><br>On 1/17/19 at 11:49 AM, LPN #1 confirmed the interventions on Resident #21's care plan documented a high-density mattress and cushion on wheelchair, rather than an air overlay mattress and dycem under and on top of the Roho cushion. The MDS nurse confirmed the interventions on Resident #21's care plan documented a high-density mattress and cushion on the wheelchair, rather than an air overlay mattress and dycem under and on top of the Roho cushion. The MDS nurse stated it was "overlooked." | F 656   |   |                      |   |
| F 686<br>SS=D  | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced  | F 686   |   | 2/26/19              |   |

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| F 686  | <p>Continued From page 9</p> <p>by:<br/>Based on observation, staff interview, and record review, it was determined the facility failed to ensure physician-ordered treatments were completed for 1 of 1 residents (Resident #21) who were reviewed for pressure ulcers. This failure had the potential to prevent healing and promote worsening of wounds. Findings include:</p> <p>The facility's policy for pressure ulcers/skin breakdown, revised March 2014, documented the physician will authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents if indicated.</p> <p>Resident #21 was admitted to the facility on 9/8/18, with diagnoses which included dementia, malnutrition, and a Stage IV pressure ulcer (full thickness skin loss with exposed bone, tendon, or muscle).</p> <p>An admission MDS assessment, dated 9/15/18, documented Resident #21 had a Stage IV pressure ulcer that was present on admission.</p> <p>A nursing note, dated 9/8/2018 at 6:55 PM, documented there was skin breakdown on Resident #21's buttocks. The wound measurements were 4.1cm x 2.3cm x 2.1cm. The note documented the wound was cleaned and there were no signs or symptoms of infection. A new dressing was applied to the wound.</p> <p>A physician's order, dated 10/19/18, directed staff to place dycem underneath and on top of Resident #21's wheelchair cushion.</p> | F 686   | <p>F686 Treatment/Services to Prevent/Heal Pressure Ulcer<br/>This facility will ensure physician-ordered treatments were completed.<br/>Dycem (a non-slip mat) is now underneath and on top of the wheelchair cushion in Resident#21's wheelchair for safety.<br/>Care plan for Resident # 21 has been reviewed and updated to indicate resident's current condition and resident's current intervention as order by Resident's Physician.<br/>Staff has been educated about the importance of following the Physician's Orders and Resident's care plans and the importance of placing Dycem (a non-slip mat) underneath and on top of the wheelchair cushion in Resident#21's wheelchair for safety.<br/>Resident #21 wound dressings has been changed per Doctor's Order. LN has been educated on the importance of following Physician's orders regarding wound dressing changes and not signing TAR when treatment has not been done.<br/>All residents has the potential to be affected by the deficient practice.<br/>Staff has been in-serviced on Federal Citation and Deficient Practice.<br/>Licensed Nurse has been educated regarding the importance of following Physician's orders regarding wound dressing changes and signing TAR after the treatment is performed.<br/>Residents with Wound dressing orders</p> |                      |   |

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| F 686  | Continued From page 10<br><br>A physician's order, dated 10/25/18, directed staff to place an air overlay to Resident #21's bed and a Roho cushion in her wheelchair every shift for skin integrity.<br><br>A physician progress note, dated 11/1/18, documented the Stage IV pressure ulcer on Resident 21's coccyx was being cleaned and monitored.<br><br>A physician progress note, dated 11/8/18, documented Resident #21 had a Stage IV pressure ulcer on the coccyx which was covered with a dressing. The note documented the family did not want to treat the wound.<br><br>A physician progress note, dated 11/27/18, documented the ulcer on Resident #21's coccyx was decreasing in size.<br><br>A physician's order, dated 12/06/18, documented staff were to provide wound care for Resident #21's pressure ulcer as follows: Wet to dry gauze dressing, wet with Microklenz solution (an antimicrobial spray), cover with a large Mepilex dressing (a foam dressing), and change daily.<br><br>Resident #21's skin/pressure ulcer care plan, updated on 12/28/18, documented Resident #21 had a pressure ulcer from a sedentary lifestyle and fragile skin. The interventions included monitoring the wound and following physician orders, using a cushion in the wheelchair, and weekly skin checks.<br><br>Resident #21's January 2019 Treatment Administration Record (TAR), documented LPN | F 686   | have been reviewed and random checks have been done to ensure LNs are changing wound dressing per Physician <input type="checkbox"/> Orders.<br>Random audits will be done by the Director of Nursing Services or Designee. Audits will be completed weekly x 4, bimonthly x 2, then monthly x 3. The results of all audits will be presented to the QAA committee for further monitoring and modification based on the findings. |                      |   |

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| F 686  | Continued From page 11<br>#2 had completed a dressing change on 1/16/19.<br><br>On 1/17/19 at 9:36 AM, LPN #1 completed a dressing change to Resident #21's pressure ulcer. LPN #1 removed the dressing, which was dated 1/15/19, and was initialed by the wound nurse. LPN #1 stated there was a foul odor and increased exudate from the last time she had changed the dressing. The wound bed was red, edges were rolled in and the area surrounding the wound was slightly red. LPN #1 confirmed the dressing was ordered to be changed daily and the wound nurse completed wound rounds on Tuesdays. LPN #1 confirmed there was an air overlay mattress on the resident's bed and there was dycem on top of the resident's wheelchair cushion, but no dycem under the cushion. LPN #1 stated there should be dycem under and on top of the Roho cushion in Resident #21's wheelchair.<br><br>On 1/17/19 at 12:48 PM, the DON stated she was aware LPN #1 removed Resident #21's dressing that morning and it was the dressing signed by the wound nurse and dated 1/15/19. The DON said she would talk with LPN #2 about signing for a dressing that was not changed.<br><br>On 1/17/19 at 4:35 PM, LPN #1 confirmed Resident #21 was using a Medline cushion (a gel-foam pressure reducing cushion) in her wheelchair and not a Roho cushion as ordered. | F 686   |   |                      |   |
| F 758<br>SS=D  | Free from Unnec Psychotropic Meds/PRN Use<br>CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental  | F 758   |   | 2/26/19              |   |

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| F 758  | <p>Continued From page 12</p> <p>processes and behavior. These drugs include, but are not limited to, drugs in the following categories:</p> <ul style="list-style-type: none"> <li>(i) Anti-psychotic;</li> <li>(ii) Anti-depressant;</li> <li>(iii) Anti-anxiety; and</li> <li>(iv) Hypnotic</li> </ul> <p>Based on a comprehensive assessment of a resident, the facility must ensure that---</p> <p>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> | F 758   |   |                      |   |

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| F 758  | <p>Continued From page 13</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure residents received antipsychotic medications only when a.) clinically indicated for the treatment of specific conditions, b.) specific target behaviors were identified and monitored, and c.) potential adverse side effects of the medication were monitored. This was true for 1 of 4 residents (Resident #12) who received antipsychotic medication. This had the potential for harm should residents receive medications without clear indication of need, target behaviors, or medication monitoring. Findings include:</p> <p>Resident #12 was admitted to the facility on 11/2/18, with a diagnosis of unspecified dementia with behavioral disturbance and was receiving hospice services for failure to thrive.</p> <p>A physician's order, dated 11/2/18, documented Resident #12 was to receive Seroquel (antipsychotic) 50 mg by mouth at bedtime for insomnia related to unspecified dementia with behavioral disturbance. On 11/30/18, insomnia was removed as a diagnosis.</p> <p>A facility consent, Psychotropic Medication Notification, dated 11/2/18, documented the specific condition treated with an antipsychotic medication for Resident #12 was dementia with behavioral disturbance. The form provided the</p> | F 758   | <p>F758 from Unnecessary Psychotropic Medications/PRN s</p> <p>This facility will ensure residents received antipsychotic medications only when a.) clinically indicated for the treatment of specific conditions, b.) specific target behaviors were identified and monitored, physician-ordered treatments were completed and c.) potential adverse side effects of the medication were monitored. Resident # 12 Seroquel 50 mg medication was discontinued by the resident's Primary Physician. Resident # 12 Care plan was reviewed and updated to indicate resident current condition. All residents have the potential to be affected by the deficient practice. Staff have been in-serviced on Federal Citation and Deficient Practice. Residents with Psychotropic medications were reviewed and care plans were updated to ensure that residents received antipsychotic medications only when clinically indicated for the treatment of specific conditions, specific target behaviors were identified and monitored, physician-ordered treatments were completed and potential adverse side effects of the medication were monitored. Resident Care plan for antipsychotic medications will be reviewed and updated</p> |                      |   |

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| F 758  | <p>Continued From page 14</p> <p>risks and benefits for Seroquel and was signed by Resident #12's responsible party. The consent stated if target behaviors were controlled, the medication should gradually be decreased to the lowest possible dosage or frequency unless otherwise indicated by the physician.</p> <p>A Social Service initial evaluation, dated 11/6/18, documented Resident #12 was pleasant but confused and received Seroquel for insomnia/irritability.</p> <p>A pharmacy consultant report, dated 11/6/18, recommended the facility attempt a GDR of Seroquel to 25 mg once daily at bedtime for one week and then discontinue. The report also documented, if necessary, a safer alternative such as an antidepressant medication should be considered. On 11/30/18, a physician accepted this recommendation and directed staff to implement the recommendation in the pharmacy report.</p> <p>An admission MDS assessment, dated 11/13/18, documented Resident #12:</p> <ul style="list-style-type: none"> <li>* was severely impaired cognitively</li> <li>* did not hallucinate or have delusions</li> <li>* did not exhibit physical or verbal behavioral symptoms directed at others</li> <li>* did not exhibit rejection of care</li> <li>* wandered 1-3 days during the 7-day observation period</li> <li>* did not intrude on the privacy of others</li> <li>* did not place himself at a significant risk for danger</li> </ul> <p>The MDS documented Resident #12 received</p> | F 758   | <p>per MDS Schedule to ensure that residents received antipsychotic medications only when clinically indicated for the treatment of specific conditions, specific target behaviors were identified and monitored, physician-ordered treatments were completed and potential adverse side effects of the medication were monitored .</p> <p>Audits will be completed weekly x 4, bimonthly x 2, then monthly x 3 by the Director of Nursing Services or Designee. The results of all audits will be presented to the QAA committee for further monitoring and modification based on the findings.</p> |                      |   |

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| F 758  | <p>Continued From page 15<br/>antipsychotic medication daily.</p> <p>A care plan, dated 11/20/18, documented Resident #12 exhibited wandering related to his dementia diagnosis. The care plan did not document the use of an antipsychotic medication. The care plan did not provide specific behaviors for which the antipsychotic medication was needed. The care plan did not direct the staff to monitor for specific behaviors, adverse drug reactions, or effectiveness of the medication.</p> <p>A Psychotropic Drug Review form, dated 11/30/18, documented the medication ordered and committee recommendations for Resident #12. The section identifying target behaviors was blank. The committee recommendation was to discontinue the Seroquel as it was contraindicated at this time. The form was signed by the DON, the pharmacy consultant, Social Services, Medical Records, the MDS nurse, and a physician.</p> <p>A pharmacy consultant report, dated 11/30/18, recommended the antipsychotic medication for Resident #12 be discontinued due to lack of behaviors to support use per the Psychotropic Drug Review meeting. On 12/6/18, the hospice physician declined the recommendation because the GDR was clinically contraindicated and Resident #12's target symptoms returned or worsened after the most recent GDR attempt within the facility. The physician responded on the report the patient was terminally ill and on hospice, and the goal was for palliative measures. Resident #12's record did not include documentation a GDR was attempted.</p> | F 758   |   |                      |   |

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| F 758  | Continued From page 16<br>Resident #12's record did not include Physician Progress Notes, or other documentation with clear indications for ordering Seroquel.<br><br>The MARs for November 2018, December 2018, and January 2019 documented Seroquel 50 mg was provided daily for Resident #12.<br><br>On 1/16/19 at 2:31 PM, the RSD stated Resident #12 was on Seroquel when he came to the facility. She thought his behaviors included wandering, verbal and physical aggression, and urinating in the trash cans. The RSD stated the CNAs tracked Resident #12's behaviors and provided the CNA "Follow Up Question Report." The report listed behaviors from 1/1/19 through 1/15/19, and included wandering 5 times, yelling/screaming 2 times, repeat movement 1 day, rejection of care 1 day, and "none of the above" was documented 21 times. The RSD stated the CNAs picked the behavior from a long list of choices. The behaviors were not specific to Resident #12. The RSD stated the licensed staff did not identify or track specific behaviors.<br><br>The pharmacy consultant report, dated 11/30/18, was signed with a different physician's signature on 1/16/19. The physician accepted the pharmacy recommendation and directed staff to implement as written.<br><br>The Resident #12's record did not include assessments, clinical indication of use, target behaviors, monitoring of behaviors, or evaluations of the medication's efficacy. | F 758   |   |                      |   |
| F 761<br>SS=E  | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)   | F 761   |   | 2/26/19              |   |

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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 |   |
| F 761  | <p>Continued From page 17</p> <p>§483.45(g) Labeling of Drugs and Biologicals<br/>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:<br/>Based on policy review, observation, and staff interview, it was determined the facility failed to ensure medications were secure and inaccessible to unauthorized staff and residents and expired medications were removed from the medication cart. This failed practice created the potential for harm if a resident obtained medications left unattended and unsecured by staff or a resident received expired medications. Findings include:</p> | F 761   | <p>F761 Label/ Store Drugs and Biologicals<br/>This facility will ensure medications were secure and inaccessible to unauthorized staff and residents and expired medications were removed from the medication cart.<br/>All residents have the potential to be affected by the deficient practice. Locks have been installed on both medication closets in both building to ensure medications are secure and</p> |                      |   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                   |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>135069</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                      | (X3) DATE SURVEY COMPLETED<br><br><b>01/18/2019</b> |
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| F 761  | <p>Continued From page 18</p> <p>The facility's policy Storage of Medication, copyrighted 2001, directed the facility to:</p> <ul style="list-style-type: none"> <li>*Store all drugs and biologicals in a safe, secure, and orderly manner.</li> <li>*The nursing staff were responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.</li> <li>*The facility would not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs were returned to the dispensing pharmacy or destroyed.</li> <li>*Drugs for external use, as well as poisons, were clearly marked and were stored separately from other medications.</li> <li>*Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals were locked when not in use, and trays or carts used to transport such items were not left unattended if open or otherwise potentially available to others.</li> </ul> <p>1. On 1/17/19 at 9:16 AM, during medication pass observation on the Galena unit, LPN #3 opened the doors to a cabinet located in the nurses station without the use of a key. The cabinet was used for storing multiple bottles of new OTC medications including: acetaminophen, ibuprofen, vitamins, cough suppressants, laxatives, Milk of Magnesia, nasal spray, etc.</p> <p>At 10:50 AM, LPN #3 stated the cabinets were not locked. She attempted to lock the doors with her keys, however the doors opened without resistance. LPN #3 stated the cabinet doors were not locked when staff left the area.</p> <p>2. On 1/17/19 at 8:13 AM, the medication storage</p> | F 761   | <p>inaccessible to unauthorized staff and residents.</p> <p>Staff have been in-serviced on Federal Citation and Deficient Practice.</p> <p>All medications in both building's medication closets and medication carts have been reviewed for expiration date. Expired medications were removed from the carts and medication storage closets. Staff have been educated about the importance of locking and securing medications. Medication carts and closets will be audited by DON or Designee atleast once every quarter to ensure that all expired medications are removed from the carts and medication storage closets. Random Audits will be done by Director of Nursing Services or Designee to ensure medication closets and carts are locked and secured.</p> <p>Audits will be completed weekly x 4, bimonthly x 2, then monthly x 3. The results of all audits will be presented to the QAA committee for further monitoring and modification based on the findings.</p> |                      |   |

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| F 761  | Continued From page 19<br>cabinets in the nurses' station on the Hemmingway unit were observed to be unattended by staff, and there were no barriers to prevent residents or visitors from entering the nurses station. There were multiple cabinets on both walls of the nurses' station which were unlocked. One cabinet had a lock and another cabinet's lock was broken. One of the unlocked cabinets had several bottles of OTC medications.<br><br>LPN #1 stated she was the charge nurse for Hemmingway unit and confirmed one tall cabinet had a broken lock and another cabinet with a lock was left unlocked and was left unattended. LPN #1 stated she had worked there for over a year and was never trained to lock the cabinet. LPN #1 stated she did not have a key to lock the cabinets. LPN #1 confirmed the cabinet that stored the OTC medications should be locked when unattended.<br><br>On 1/17/19 at 10:30 AM, the DON observed the unlocked cabinets where OTC medications were stored. The DON confirmed the cabinets did not lock and agreed the medications should be locked in the cabinet.<br><br>3. On 1/17/19 at 10:50 AM, an inspection of the medication cart on the Hemmingway unit was completed with LPN #1. The medication cart had an open bottle of Zinc in the top drawer which expired on 10/2018. LPN #1 confirmed the Zinc was expired and still in the medication cart. LPN #1 disposed of the expired Zinc. | F 761   |   |                      |   |
| F 770<br>SS=E  | Laboratory Services<br>CFR(s): 483.50(a)(1)(i)<br><br>§483.50(a) Laboratory Services.   | F 770   |   | 2/26/19              |   |

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| F 770  | <p>Continued From page 20</p> <p>§483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>(i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, and review of facility records, it was determined the facility failed to ensure glucometer, glucose control testing was performed daily. This failure had the potential to effect 4 of 4 residents on the Hemingway unit who required daily blood glucose testing to be inaccurate. Findings include:</p> <p>The glucometer log book in the nurse's station on the Hemingway unit had instructions for staff to complete control checks on the glucometer's every night shift. The instructions also stated any abnormal high or low on a resident blood glucose level indicated the need to complete a control check.</p> <p>The glucometer control testing log documented the control was completed on 21 days out of 108 days between 10/01/18 and 1/16/19. Glucometer control testing was not completed for October 2018 on the 1-4, 6-7, 9-11, 13,16, 18-22, and 24-31. For November 2018 the glucometer was not tested on the 1-5, 7-9, 11-24, 26-27, and the 29-30. For December 2018 the glucometer was not tested on the 1-2, 5-6, 8, 10-21, 26-28, and 31. There were no glucometer tests documented in January 2019.</p> | F 770   | <p><b>F770 Laboratory Services</b></p> <p>This facility will ensure glucometer, glucose control testing is performed daily. All diabetic residents with blood glucose level checks have the potential to be affected by the deficient practice. Staff have been in-serviced on Federal Citation and Deficient Practice and the importance of testing the glucometer, glucose control testing daily. Glucose control testing for all glucometers in both buildings have been performed. Staff has been educated about the importance of testing the glucometer, glucose control testing daily. Random Audits will be done by Director of Nursing Services or Designee to ensure that glucometer, glucose control testing is performed daily. Audits will be completed weekly x 4, bimonthly x 2, then monthly x 3. The results of all audits will be presented to the QAA committee for further monitoring and modification based on the findings.</p> |                      |   |

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

PRINTED: 02/22/2019  
FORM APPROVED  
OMB NO. 0938-0391

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| F 770  | Continued From page 21<br><br>On 1/17/19 at 12:00, LPN #1 stated she worked the dayshift and did not know about checking the glucometer. LPN #1 stated there were four residents on the Hemingway unit who had their blood glucose levels tested and one glucometer was used for those residents.<br><br>On 1/17/19 at 12:05 PM, the DON confirmed the glucometer was not tested or calibrated nightly as staff were directed. | F 770   |   |   |



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
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May 2, 2019

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

Provider #: 135069

Dear Mr. Royeca:

On **January 18, 2019**, an unannounced on-site complaint survey was conducted at Bell Mountain Village & Care Center. Two surveyors conducted an unannounced onsite complaint investigation in conjunction with the recertification survey at the facility from January 14, 2019 through January 18, 2019. Observations were conducted throughout the facility. Multiple interviews were conducted with residents, family members, and staff members. There were 17 residents reviewed in the sample. Facility policies were also reviewed.

The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

**Complaint #ID00007875**

**ALLEGATION#1:**

The facility failed to provide physician-ordered medical care and treatment for pressure ulcers.

**FINDINGS #1:**

One resident's record documented she received treatment from a wound clinic in June 2018. The resident returned from a wound clinic visit without new orders on Friday, 6/22/18. On Monday 6/25/18 the facility received new treatment orders from the wound clinic and the orders were entered in the electronic medical record to begin on 6/26/18. A nurse who changed the resident's dressing was interviewed and recalled having to find out what type of dressing was ordered. She then changed the dressing and documented the treatment on 6/26/18. Another nurse changed

the dressing and documented the treatment on 6/28/18. The person who drove the resident to the 6/29/18 wound clinic visit was interviewed. The person did not recall details of the visit. The resident's wounds were healed at the time of the survey. Deficient practices were not identified related to the care of this resident's pressure ulcer.

Deficient practices were, however, identified related to the care and treatment of pressure ulcers of another resident reviewed during the survey. The other resident was admitted to the facility in September 2018, with diagnoses which included dementia, malnutrition, and a Stage IV pressure ulcer (full thickness skin loss with exposed bone, tendon, or muscle).

A nursing note, dated 9/8/18 at 6:55 PM, documented there was skin breakdown on the resident's buttocks. The wound measurements were 4.1 cm x 2.3 cm x 2.1 cm. The note documented the wound was cleaned and there were no signs or symptoms of infection. A new dressing was applied to the wound.

A physician's order, dated 10/19/18, directed staff to place dycem underneath and on top of the resident's wheelchair cushion.

A physician's order, dated 10/25/18, directed staff to place an air overlay to the resident's bed and a Roho (pressure relief) cushion in her wheelchair every shift for skin integrity.

A physician progress note, dated 11/27/18, documented the ulcer on the resident's coccyx was decreasing in size.

A physician's order, dated 12/6/18, documented staff were to provide wound care for the resident's pressure ulcer as follows: Wet to dry gauze dressing, wet with Microklenz solution (an antimicrobial spray), cover with a large Mepilex dressing (a foam dressing), and change daily.

The resident's January 2019 Treatment Administration Record, documented LPN #2 had completed a dressing change on 1/16/19.

On 1/17/19 at 9:36 AM, LPN #1 completed a dressing change to the resident's pressure ulcer. LPN #1 removed the dressing, which was dated Tuesday 1/15/19, and initialed by the wound nurse. LPN #1 stated there was a foul odor and increased exudate from the last time she had changed the dressing. The wound bed was red, edges were rolled in, and the area surrounding the wound was slightly red. LPN #1 confirmed the dressing was ordered to be changed daily and the wound nurse completed wound rounds on Tuesdays. LPN #1 confirmed there was an air overlay mattress on the resident's bed and there was dycem on top of the resident's wheelchair cushion, but no dycem under the cushion. LPN #1 stated there should be dycem under and on top of the Roho cushion in the resident's wheelchair.

Darwin Royeca, Administrator  
May 2, 2019  
Page 3 of 3

On 1/17/19 at 12:48 PM, the DON stated she was aware LPN #1 removed the resident's dressing that morning and it was the dressing signed by the wound nurse dated 1/15/19. The DON said she would talk with LPN #2 about documenting a dressing change that was not completed.

On 1/17/19 at 4:35 PM, LPN #1 confirmed the resident was using a Medline cushion (a gel-foam pressure reducing cushion) in her wheelchair and not a Roho cushion as ordered.

The allegation was substantiated, and the facility was cited with deficient practice at F686 (Prevention and Treatment of Pressure Ulcers). Please refer to the CMS-Form 2567 for the further details.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

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

Sincerely,



Sylvia Creswell, LSW  
Long Term Care Program

SC/lj



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June 24, 2019

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

Provider #: 135069

Dear Mr. Royeca:

On **January 18, 2019**, an unannounced on-site complaint survey was conducted at Bell Mountain Village & Care Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007974**

ALLEGATION #1:

The facility failed to ensure adequate numbers of staff were provided.

FINDINGS #1:

An unannounced onsite complaint investigation was conducted in conjunction with a recertification survey at the facility from 1/14/19 to 1/18/19. Observations were conducted, Resident Council minutes were reviewed, and interviews were conducted with residents, family members, and staff members. There were 17 resident records also reviewed.

The facility consisted of 2 buildings with 27 residents and four staff members to care for them during the 12-hour night shift: one Registered Nurse (RN) and three Certified Nurse Aides (CNAs). Facility records documented an emergency situation with a resident in one building,

which required 3 staff. This left one Certified Nursing Assistant (CNA) as the only staff member in the other building. There were no incidents reported as a result of the CNA working in the building alone.

However, Resident Council Meeting minutes, dated 9/2018 to 12/2018, documented residents had expressed ongoing concerns related to call light response times without resolution.

On 1/16/19 at 10:00 AM, a group of five Resident Council members, including the Resident Council president, were interviewed. All five residents agreed there were problems with the call lights for the past several months. Some of the call light concerns included staff not answering call lights in a timely manner, times when the call lights were not answered for over an hour, a resident being left on the toilet for one and a half hours, and the staff not leaving the call lights within reach of the residents.

On 1/17/19 at 5:35 PM, the Resident Services Director (RSD) stated she was the person responsible for the Resident Council Minutes and follow-up. The RSD stated when residents brought up concerns, she went to the department head responsible for the issue, asked the department head to write up what was done, took the response back to the Resident Council, and asked the Council if the response was acceptable. She stated the first meeting she oversaw was in 9/2018. The RSD said the CNAs were in-serviced on call light response times. The RSD confirmed the residents' concerns with call lights were brought up over several months without resolution.

The RSD provided documentation of a staff in-service which documented the staff received training for call lights to be answered in an appropriate and timely manner. The RSD confirmed this was the only in-service for staff about call lights since 9/17/18, and there were no further in-services after 9/21/18.

#### CONCLUSIONS:

It could not be determined the facility failed to ensure adequate numbers of staff were provided. Therefore, the allegation was unsubstantiated. However, it was determined the facility failed to ensure Resident Council concerns and grievances regarding call light response times were resolved. Therefore, deficient practice was identified and cited at F565.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Thank you for the courtesies and assistance extended to us during our visit. Based on the findings of the investigation, deficiencies were cited and included on the Statement of

Darwin Royeca, Administrator  
June 24, 2019  
Page 3

Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

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 black ink, appearing to read "Laura Thompson", is positioned above the typed name.

LAURA THOMPSON, RN, Supervisor  
Long Term Care Program

LT/slj