



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE- Governor
DAVE JEPPESEN- Director

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

February 20, 2019

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

Provider #: 135075

Dear Mr. Lloyd:

On **January 18, 2019**, a survey was conducted at Valley Vista Care Center of St Maries 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 actual 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.) **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 **March 4, 2019**. Failure to submit an acceptable PoC by **March 4, 2019**, may result in the imposition of civil monetary penalties by **March 25, 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*.

We are recommending that Centers for Medicare & Medicaid Services (CMS) Region X impose the following remedy(ies):

- Civil Money Penalty
- Denial of payment for new admissions effective April 18, 2019

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.**

Charles Lloyd, Administrator
February 20, 2019
Page 3 of 3

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.

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/ta/bid/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 **March 4, 2019**. If your request for informal dispute resolution is received after **March 4, 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/lj

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

PRINTED: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted January 14, 2019 to January 18, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Teresa Kobza, RDN, LD, Team Coordinator Linda Kelly, RN Kate Johnsrud, RN Presie Billington, RN Margaret Layne, RN</p> <p>Abbreviations:</p> <p>ADL = Activities of Daily Living AROM = Active Range of Motion CNA = Certified Nursing Assistant COPD = Chronic Obstructive Pulmonary Disease DNS = Director of Nursing Services IDT = Interdisciplinary Team LPM = Liters Per Minute LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set mg = milligrams PRN = As Needed PT = Physical Therapy RN = Registered Nurse RNA = Restorative Nursing Assistant RNP = Restorative Nursing Program ROM = Range of Motion RSC = Resident Services Coordinator RSM = Resident Services Manager</p>	F 000			
F 609 SS=D	<p>Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)</p>	F 609		4/1/19	

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

TITLE

(X6) DATE

Electronically Signed

03/04/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 609	<p>Continued From page 1</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, record review, policy review, and review of Incident and Accident reports, it was determined the facility failed to ensure all allegations of potential abuse or neglect were reported to the Administrator and State Survey Agency within 2 hours for 1 of 2 residents (Resident #40) reviewed for abuse/neglect. This had the potential to</p>	F 609	<p>Affected Residents Resident #40's roommate was interviewed on 1/17/2019 during the survey. The roommate stated that he did not witness anything. Resident #40 continues to have no negative psychosocial issues because of the incident on 12/29/2018</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 609	<p>Continued From page 2</p> <p>adversely affect all residents residing in the facility. The deficient practice created the potential for harm if abuse was not reported and investigated completely. Findings include:</p> <p>The facility's Abuse policy, revised on 11/22/16, stated all reports of abuse, neglect, and injuries of unknown origin, were to be thoroughly investigated. All employees observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the Administrator, DNS, or charge nurse. The supervisor or charge nurse should complete a Report of Incident/Accident form and submit the original to the DNS within 24 hours of the incident or accident.</p> <p>This policy was not followed.</p> <p>Resident #40 was admitted to the facility on 2/24/18, with multiple diagnoses including dementia and stroke.</p> <p>A quarterly MDS assessment, dated 11/29/18, documented Resident #40 had severe cognitive impairment and required the assistance of one to two staff persons with his ADLs.</p> <p>Resident #40's Self Deficit care plan, dated 2/23/18, documented he required extensive assistance of one to two staff members with toileting, incontinence care, bed mobility, and transfers.</p> <p>An I&A report, documented an allegation of staff abuse occurred on 12/29/18, and it was reported to the administration on 12/31/18, two days later. The report documented Resident #40 was</p>	F 609	<p>All residents could be at risk for this citation.</p> <p>Corrective Action The Abuse Policy and Procedure was reviewed to ensure regulatory requirements. An all staff in-service with competency will be held on 3/15/2019 to review the 2-24-hour reporting timeline. L.P.N.#5 and C.N.A. #4 were formally educated by the Director of Nursing</p> <p>Systematic Changes Audits on allegations of abuse, neglect, exploitation, mistreatment, including injuries of unknown origin are reported immediately, but not later than 2 hours, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator of the facility and to the Bureau of Facility Standards.</p> <p>Monitoring Audits will be completed weekly for two months, every other week for two months, and then quarterly. Audits will be reported to the Q.A.P.I. committee monthly. Administrator is responsible for compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 609	Continued From page 3 combative during nursing care and CNA #5 shouted at Resident #40, and said Resident #40 needed to "knock it off" and "grow up." The I&A report documented CNA #5 pointed her finger at Resident #40's face when he continued to be aggressive and told Resident #40 to stop and she was going to write a report about him to get him kicked out of the facility. The I&A report also documented CNA #4 heard CNA #5 telling Resident #40 "I can't believe you are a grown man acting like that." A Staff Statement completed by LPN #5 documented on 12/29/18 at 6:00 PM CNA #4 reported the incident to her. LPN #5 stated she told CNA #4 to "report it" and put the report under the Administrator's door because they, LPN #5 and CNA #4, were getting off shift. LPN #5 also documented if CNA #4 ever "felt that way again" to get the resident's nurse and "...let us decide what to do." On 1/17/19 at 2:59 PM, the DNS said any allegation of potential abuse should be reported to her or the Administrator within 2 to 24 hours and the written report should be completed within 5 days. The DNS said CNA #5 was terminated upon completion of their investigation. The DNS said she educated LPN #5 and CNA #4 regarding timely reporting and prevention of potential abuse. The DNS said she enrolled LPN #5 and CNA #4 in a course "Abuse Prevention in Persons with Dementia: The Basics" and asked them to complete the course within 7 days of their enrollment to the course.	F 609			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		4/1/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 610	<p>Continued From page 4</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, record review, Incident and Accident (I&A) report review, and policy review, it was determined the facility failed to ensure allegations of verbal abuse reported by staff were thoroughly investigated for 1 of 2 residents (Resident #40) reviewed for abuse/neglect. This deficient practice placed all residents residing in the facility at risk for harm from undetected physical and/or verbal abuse. Findings include:</p> <p>The facility's Abuse policy, revised on 11/22/16, stated all reports of abuse, neglect, and injuries of unknown source, were to be thoroughly investigated. All employees observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the Administrator, DNS, or Charge Nurse. The policy</p>	F 610	<p>Affected Residents Resident #40's roommate was interviewed on 1/17/2019 during the survey. The roommate stated that he did not witness anything. Resident #40 continues to have no negative psychosocial issues because of the incident on 12/29/2018 All residents could be affected by this citation Corrective Action The Administrator re-read the Federal Guidance and Facility Policy and Procedure to meet regulatory compliance to ensure a thorough investigation is completed for allegations of abuse. Systematic Changes Either the Corporate Compliance Director,</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 610	<p>Continued From page 5</p> <p>defined verbal abuse as any use of oral, written, or gestured language that willfully included disparaging and derogatory terms to residents or their families. The policy stated the nurse should assess the individual and document related findings.</p> <p>The policy stated the individual conducting the investigation should at a minimum:</p> <ul style="list-style-type: none"> *Interview the person(s) reporting the incident. *Interview any witnesses to the incident. *Interview the resident (as medically appropriate). *Interview staff members (on all shifts) who have contact with the resident during the period of the alleged incident. *Interview the resident's roommate, family members, and visitors. *Interview other residents to whom the accused employee provides care or services. <p>This policy was not followed.</p> <p>Resident #40 was admitted to the facility on 2/24/18, with multiple diagnoses including dementia and stroke.</p> <p>A quarterly MDS assessment, dated 11/29/18, documented he had severe cognitive impairment and he required the assistance of one to two staff members for his ADLs.</p> <p>Resident #40's Self Deficit care plan, dated 2/23/18, documented he required extensive assistance of one to two staff members with toileting, incontinence care, bed mobility, and transfers.</p>	F 610	<p>Director of Nursing or an alternate designee will review any investigation that the Administrator completes to ensure a thorough investigation is completed as outlined in Federal Regulations and Facility Policy and Procedures. An audit form will be used to ensure essential components of the investigation are completed. At a minimum the facility will ensure the following were present were applicable:</p> <ul style="list-style-type: none"> Interview with person(s) reporting the incident Interview with witness to the incident Interview with the resident (as medically appropriate) Interview with staff members (on all shifts) who have contact with the resident during the period of the alleged incident Interview of the resident's roommate, family members, visitors, etc. Interview of other residents to whom the accused employee provides care or services <p>Monitoring Audits will be completed weekly for two months, every other week for two months, and then quarterly. Audits will be reported to the Q.A.P.I. committee monthly. Administrator is responsible for compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 610	<p>Continued From page 6</p> <p>An I&A report, documented an allegation of staff abuse occurred on 12/29/18, and it was reported to the administration on 12/31/18, two days later. The report documented Resident #40 was combative during nursing care and CNA #5 shouted at Resident #40, and said Resident #40 needed to "knock it off" and "grow up." The I&A report documented CNA #5 pointed her finger at Resident #40's face when he continued to be aggressive and told Resident #40 to stop and she was going to write a report about him to get him kicked out of the facility. The I&A report also documented CNA #4 heard CNA #5 telling Resident #40 in the dining room "I can't believe you are a grown man acting like that." CNA #4 reported the incident to LPN #5.</p> <p>A Staff Statement completed by LPN #5 documented on 12/29/18 at 6:00 PM, CNA #4 reported the incident to her. LPN #5 stated she told CNA #4 to "report it" and put the report under the Administrator's door because they, LPN #5 and CNA #4, were getting off shift. LPN #5 also documented if CNA #4 ever "felt that way again" to get the resident's nurse and "...let us decide what to do."</p> <p>The I&A report documented CNA #5 was placed on leave during the investigation. Attached to the report were written statements from CNA #5, CNA #4, LPN #5, and the Administrator. The Administrator documented he was unable to interview Resident #40 due to his cognitive impairment. The I&A report did not include statements or interviews of Resident #40's roommate or of other residents who were under the care of CNA #5.</p>	F 610			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 610	Continued From page 7 The I&A report concluded the abuse by CNA #5 was substantiated and no psychosocial harm was noted to Resident #40. The report was signed by the Administrator on 1/4/19 at 5:50 PM. Resident #40's record did not include documentation he was assessed or observed for signs of psychosocial harm. On 1/17/19 at 2:59 PM, the DNS said the I&A report did not include interviews of Resident #40, his roommate, and other residents who were under the care of CNA #5. The DNS said Resident #40 should have been placed on alert charting and monitored for 72 hours. On 1/18/19 at 10:00 AM, the Administrator said he interviewed Resident #40 and he remembered Resident #40 telling him "I will kick his ass." The Administrator said he did not formally write a report of his interview of Resident #40. The Administrator said Resident #40 had a roommate and he did not interview Resident #40's roommate or the other residents who were under the care of CNA #5. The Administrator said it was an oversight.	F 610			
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive	F 636		4/1/19	

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

PRINTED: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 636	<p>Continued From page 8</p> <p>assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:</p> <ul style="list-style-type: none"> (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. <p>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes</p>	F 636			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 636	<p>Continued From page 9</p> <p>prescribed in §413.343(b) of this chapter do not apply to CAHs.</p> <p>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)</p> <p>(iii) Not less than once every 12 months. 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 the MDS was completed timely for 1 of 15 residents (Resident #2) reviewed for MDS completion. The failure created the potential for harm if care and services provided did not meet resident needs. Findings include:</p> <p>Resident #2 was admitted to the facility on 10/22/18, with multiple diagnoses including heart failure, chronic pain, difficulty walking, macular degeneration, hypertension, and lower back pain.</p> <p>An admission MDS assessment, dated 10/29/18, documented Resident #2 was independent with decision making and a resident interview was not completed. The MDS was signed on 1/15/19, which was 78 days after it was initiated.</p> <p>On 1/16/19 at 3:33 PM, the MDS RN stated Resident #2's 10/29/18 MDS was started and not completed until 1/15/19. The MDS RN stated she did not know what happened.</p>	F 636	<p>Affected Residents Found that resident #2's MDS was not completed per RAI guidelines.</p> <p>Corrective Action An audit that was completed on 01/30/2019 was done to ensure that all current residents most recent OBRA and/or PPS assessment was completed and submitted. No other residents were identified during this audit as having incomplete MDS assessments per RAI guidelines.</p> <p>The MDS Nurse and Director of Nursing are attending a comprehensive MDS training March 12, 13, and 14 2019 by a certified MDS instructor.</p> <p>Systematic Changes Weekly audits will be conducted of all residents (current and those that were admitted or discharged within the 7 day period prior to the audit). To ensure that OBRA and/or PPS assessments were completed and transmitted per RAI</p>		

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

PRINTED: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 636	Continued From page 10	F 636	<p>guidelines. Audits will be continued indefinitely.</p> <p>Monitoring Admission and discharge logs will be reviewed Monday thru Friday to ensure appropriate opening/completion of entry/discharge assessments. Clinical software allows for software to determine OBRA/PPS due each month. This will be checked against manual audit to ensure accuracy. Audits will be completed weekly for two months, every other week for two months, and then quarterly. Audits will be reported to the Q.A.P.I. committee monthly.</p> <p>The Administrator, Director of Nursing, and/or Designee are responsible for compliance.</p>		
F 656 SS=D	<p>Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)</p> <p>§483.21(b) Comprehensive Care Plans §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 - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as</p>	F 656		4/1/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 656	<p>Continued From page 11</p> <p>required under §483.24, §483.25 or §483.40; and</p> <p>(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).</p> <p>(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.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(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.</p> <p>(C) Discharge plans in the comprehensive care 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 observation, resident interview, staff interview, record review, and policy review, it was determined the facility failed to ensure a comprehensive care plan was developed for 2 of 15 residents (#12 and #21) whose records were reviewed. This failure created the potential for harm if residents did not receive adequate care and treatment to meet their needs. Findings include:</p>	F 656	<p>Affected Residents</p> <p>After review, 2 of 15 residents were noted for deficient practice. Resident #12's care plan did not include a section on pain management to include his use of the routine and PRN pain medication, nor for attempting any non-pharmacological interventions for pain management prior to administering pain medication. Resident #21's care plan, dated 8/1/18,</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 656	<p>Continued From page 12</p> <p>The facility's Care Plans, Comprehensive Person-Centered policy, revised 12/2016, documented a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident.</p> <p>This policy was not followed.</p> <p>1. Resident #12 was admitted to the facility on 1/12/17, with diagnoses which included Alzheimer's disease, seizure disorder, anxiety, and depression.</p> <p>Resident #12's record included physician orders, dated 2/19/18, for Norco (a narcotic pain medication) 7.5mg of by mouth three times a day, and daily PRN for pain.</p> <p>A quarterly MDS assessment, dated 10/1/18, documented Resident #12 was severely cognitively impaired. The assessment documented Resident #12 received scheduled and PRN pain medication, but no "non-medication interventions for pain." The MDS documented Resident #12 received opioid pain medication on seven days out of seven during the look back period.</p> <p>Resident #12's December 2018 MAR, documented Resident #12 received routine pain medication three times a day every day of the month and required as needed pain medication an additional eight times during the month.</p> <p>Resident #12's MAR for January 2019, documented Resident #12 received routine pain</p>	F 656	<p>did not address his brace and splint.</p> <p>Corrective Action: Upon noted deficiency a pain care plan was developed for resident #12 and resident #21's care plan was immediately updated to address his brace and splint.</p> <p>An all staff in-service on 3/12/2019 will review the guidance surrounding care planning and updating care plans. The Director of Nursing will re-educate the Nursing staff about the care planning system and process by 3/29/2019.</p> <p>Systemic Changes Facility will recognize all residents who have braces or splints to ensure accuracy of care planning. For any resident receiving orders to initiate use of new splints or braces, the unit managers will ensure these are added to the resident's care plan. Therapy will do quarterly audits and provide a list to unit managers, MDS, and DNS of residents who use splints/braces and unit managers and MDS will verify that it is care planned appropriately for accuracy. Pain management care plans will be updated for all residents. Residents who trigger for pain on the MDS will trigger review by unit managers to ensure care plan is appropriate for resident</p> <p>Monitoring</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 656	<p>Continued From page 13</p> <p>medication three times a day from 1/1/19 to 1/16/19, and required as needed pain medication an additional three times.</p> <p>Resident #12's care plan did not include a section on pain management to include his use of the routine and PRN pain medication, nor for attempting any non-pharmacological interventions for pain management prior to administering pain medication.</p> <p>On 1/17/19 at 2:30 PM, LPN #1 stated a care plan for Resident #12 was not developed related to the administration of routine and PRN pain medication, nor for the implementation of non-pharmacological pain management interventions.</p> <p>2. Resident #21 was admitted to the facility on 8/1/17, with multiple diagnoses which included stroke with left hemiplegia (paralysis).</p> <p>A quarterly MDS assessment, dated 10/26/18, documented Resident #21 was cognitively intact and had functional range of motion impairment to his upper and lower extremities on one side.</p> <p>A physician's order, dated 4/5/18, documented Resident #21 was discharged from PT and caregivers were trained to put on/remove his left upper extremity arm support.</p> <p>On 1/14/19 at 2:30 PM, Resident #21 said he received PT three times a week for his lower extremities. Resident #21 said he was not receiving PT for his left upper arm. Resident #21 stated he could not move his left upper arm since he had a stroke. Resident #21 said he used a</p>	F 656	<p>Audits will be completed weekly for two months, every other week for two months, and then quarterly. Audits will be reported to the Q.A.P.I. committee monthly.</p> <p>The Administrator, Director of Nursing, and/or Designee are responsible for compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 656	Continued From page 14 splint whenever he was up in his wheelchair. On 1/15/19 at 11:29 AM, Resident #21 was observed in bed and he was wearing a brace on his lower left leg. On 1/15/19 at 11:38 AM, Resident #21 was observed in his power wheelchair wearing a splint on his left upper arm. On 1/15/19 at 12:24 PM, Resident #21 was observed in the smoking area with a splint on his left upper extremity. Resident #21's care plan, dated 8/1/18, did not address his brace and splint. On 1/6/19 at 12:12 PM, the Physical Therapist said Resident #21 had left sided hemiplegia and complained of pain to his left shoulder. The Physical Therapist said Resident #21 should wear his splint when he was up in his power wheelchair to provide support of his left arm otherwise, his left arm hung down and put stress on his shoulder causing pain. On 1/17/19, at 11:15 AM, RN #3 said Resident #21 was admitted to the facility with his leg brace and splint on his left upper arm. RN #2 said Resident #21's left upper splint should be on when he was up in his wheelchair and off when he was in bed. RN #3 said Resident #21's AFO and splint should have an order and should have been addressed in his care plan.	F 656			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		4/1/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 657	<p>Continued From page 15</p> <p>§483.21(b)(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>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' care plans were revised as care needs changed for 1 of 15 residents (Resident #46) whose care plans were reviewed. This failure had the potential for harm if care and services were not provided due to inaccurate information. Findings include:</p> <p>Resident #46 was admitted to the facility on</p>	F 657	<p>F657</p> <p>Affected Residents Resident #46's ADL care plan was not updated when Resident #46's behavioral issues presented and she required two staff members to be present when physical contact was required.</p> <p>Corrective Action</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 657	<p>Continued From page 16 5/4/18, with diagnoses including dementia, difficulty in walking, muscle weakness, and repeat falls.</p> <p>A quarterly MDS assessment, dated 12/12/18, documented Resident #46 was cognitively intact and required extensive assist of one staff person with all cares except eating.</p> <p>On 1/16/19 at 11:05 AM, the RSM stated Resident #46 had behavioral issues which included being accusatory towards staff. The RSM stated one of the identified practices used to keep Resident #46 safe, required the assistance of two staff persons when physical contact was required.</p> <p>Resident #46's AROM and ADL care plan areas were not updated with the appropriate level of care identified by the RSM for two person assistance with physical contact as follows:</p> <p>a. The care plan area addressing Resident #46's AROM, dated 6/29/18, documented one staff member assisted Resident #46 with AROM to her upper and lower extremities seven days a week. The care plan documented the staff person was to assist Resident #46 with AROM exercises of two to three sets of 10 repetitions for her knee and hip flexion, two to three sets of 10 repetitions to her ankle and shoulder, and 10 repetitions of trunk flexion and extension.</p> <p>b. The care plan area addressing Resident #46's ADLs, dated 12/16/18, documented one staff member assisted Resident #46 with transfers, bed mobility, ambulation, dressing, and personal hygiene.</p>	F 657	<p>Upon noted deficiency, residents care plan was updated immediately</p> <p>Systematic Changes To ensure that residents get the care required: 1.) A list will be provided by the behavior care resident services manager and social services regarding two person requirements during care. 2.) Audits will be performed quarterly to assure that RA care plan is appropriate and coincides with additional care plans. 3.) Quarterly audits will continue indefinitely</p> <p>Monitoring: Audits will be completed weekly for two months, every other week for two months, and then quarterly to ensure the RA care plan is appropriate and coincides with additional care plans. Audits will be reported to the Q.A.P.I. committee monthly. Director of Nursing, and/or Designee are responsible for compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 657	Continued From page 17 On 1/16/19 at 2:14 PM, RNA #2 stated Resident #46's care plan did not reflect her current need for two staff persons when physical contact was necessary. On 1/16/19 at 2:45 PM, LPN #2 stated Resident #46 required two staff members to complete her RNP due to behavioral issues and safety concerns. On 1/16/19 at 11:05 AM, the RSM stated Resident #46's ADL care plan was not updated when Resident #46's behavioral issues presented and she required two staff when physical contact was required.	F 657			
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, policy review, and Activity Calendar review, it was determined the facility failed to ensure there was a variety of activities, and evening activities scheduled to meet the needs of residents with cognitive impairment who resided	F 679	F679 Activities Affected Residents Resident #60 and #46 were reassessed and care plans updated. All residents could be affected by this	4/1/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 679	<p>Continued From page 18</p> <p>in the non-locked behavioral unit. This was true for 3 of 3 residents (#41, #46, and #60) reviewed for activities and resided in the unlocked behavioral unit. This created the potential for residents to become bored and foster an increase in negative behaviors when not provided with meaningful engaging activities throughout the day and evening. Findings include:</p> <p>The facility's Activity's Evaluation policy, dated 5/2013, documented residents' activities should be meaningful and individualized according to their needs.</p> <p>The January 2019 Activity Calendar for the residents documented activities occurred seven days a week with different times of the day when activities were provided. The Activity Calendar documented the following times:</p> <ul style="list-style-type: none"> - Sundays 9:00 AM to 3:00 PM or 4:00 PM - Mondays 9:00 AM to 4:00 PM or 4:30 PM - Tuesdays 9:00 AM to 4:00 PM or 4:30 PM - Wednesdays 8:30 AM or 9:00 AM to 4:30 PM or 6:30 PM - Thursdays 9:00 AM to 3:00 PM, 4:00 PM or 5:30 PM - Fridays 10:00 AM or 10:30 AM to 2:00 PM, 3:30 PM, 4:00 PM or 6:30 PM - Saturdays 10:00 AM or 11:30 AM to 2:00 PM or 3:30 PM. <p>The activity calendar documented six days during the month of January 2019 where an activity was scheduled after 5:00 PM.</p> <p>1. Resident #60 was admitted to the facility on</p>	F 679	<p>citation</p> <p>Corrective Action All residents in the facility were reassessed for activity preferences and care plans were updated to ensure they were individualized to resident preference. The facility created a one-page document called "Who I am" that identifies activities of interest to the resident to ensure staff invite, have them attend, or include them as behavioral plan intervention. Each activity that is planned will have a list of residents identified that should attend the specific activity in the facility. An all staff in-service will be held on 3/15/2019 discussing the importance of knowing the resident activity preferences and where to locate the information about each specific resident.</p> <p>Systematic Changes Residents will be assessed about activity preferences upon admission, annually, change-of-condition or as needed. The activity care plan will be reviewed in the Interdisciplinary Team on a quarterly basis for compliance.</p> <p>Monitoring Visual audits will be conducted by the Leadership team and or designee(s) to identify if Residents are engaged in meaningful activities as outlined in their individualized Activity Care Plan. Audits will be completed weekly x 4 weeks every other week x4 weeks, and monthly x3</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 679	<p>Continued From page 19</p> <p>2/4/15, with diagnoses including dementia with behavioral disturbances, depression, and anxiety.</p> <p>An annual MDS assessment, dated 6/27/18, documented Resident #60's activity preferences were having books and magazines she liked, listening to music, pet visits, keeping up with the news, and participating in favorite activities.</p> <p>A quarterly Activity Assessment, dated 9/27/18, documented Resident #60's activity preferences were listening to music, pet visits, family and friend visits, going to the beauty parlor, and walking/wheeling around the facility in her wheelchair. The assessment documented Resident #60 had no interest in movies/videos, writing, group discussions, and exercise.</p> <p>The care plan area addressing Resident #60's Activities, documented she enjoyed activities involving balls, because she was a professional softball player, she enjoyed assisting staff when they were writing statements, she enjoyed trivia, she enjoyed socializing in common areas, but would only join in the conversation when asked a question, she enjoyed music, and watching all Disney movies. The care plan did not include the interests identified as very important to her on the MDS or quarterly activities assessment and included some activities that Resident #60 had identified as "no" interest or past interests on her care plan.</p> <p>Resident #60's Activities Flowsheet, dated 12/1/18 through 1/16/19, documentation did not include documentation of pet visits, going to the beauty parlor, books and magazines, or walking</p>	F 679	<p>weeks. Audits will be reported to the Q.A.P.I. meeting on a monthly basis. Reviews on Activity Assessments and Care Plans will begin starting the next scheduled quarterly MDS Assessment.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 679	<p>Continued From page 20</p> <p>and/or wheeling around. The flowsheets documented Resident #60 participated in a music activity on 12/7/18, 12/14/18, 12/21/18, 12/28/18, and 1/7/19. The flowsheets documented she did not watch Disney movies, participate in trivia, or participate in activities involving balls. The flowsheet documented she was actively socializing with other residents in the common area from 1/1/19 through 1/16/19. Resident #60 had minimal participation in activities that were identified on her care plan and her activities were not individualized with her identified interests.</p> <p>On 1/14/19 at 12:50 PM, Resident #60 was observed near the nurses' station sitting in her wheelchair with her back to the TV and her eyes were closed. Other residents were sitting quietly in the same area. Resident #60 was observed from 12:50 PM through 1:47 PM without changes until staff assisted her to the restroom and then into her bed. Resident #60's TV in her room was not turned on or music turned on when CNA #7 left the room.</p> <p>On 1/15/19 at 11:00 AM, Resident # 60 was observed in the hallway near the nurses' station sitting quietly and other residents around her were sitting quietly.</p> <p>On 1/15/19 at 11:45 AM, Resident #60 was observed as staff assisted her in her wheelchair into the dining room for lunch.</p> <p>On 1/15/19 at 1:12 PM, Resident #60 was observed in bed with no TV or music playing.</p> <p>On 1/15/19 at 4:33 PM, Resident #60 was observed sitting in a lounge chair near the</p>	F 679			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 679	<p>Continued From page 21</p> <p>nurses' station. The TV was observed playing a show that was not Disney. Resident #60 was observed sitting quietly with her eyes closed. Resident #60 was observed from 4:33 PM to 5:28 PM in the same position with her eyes periodically closed until staff assisted her into her wheelchair and assisted her to the dining room for dinner.</p> <p>On 1/16/19 at 11:00 AM, Resident #60 was observed asleep in bed with the TV on and a show that was not Disney was playing.</p> <p>On 1/17/19 at 11:51 AM, the Activities Director stated Resident #60 enjoyed activities involving balls and watching kids' arts and craft demonstrations. The Activities Director stated Resident #60 enjoyed Disney movies in the fireside room. The Activities Director stated she was aware that individualized activities were not provided consistently for Resident #60.</p> <p>The fireside room was a room that contained movies (including Disney), books, games, puzzles, and various other activities. Resident #60 was not observed to enter the fireside room for the duration of the observations. The fireside room was empty for the majority of the survey with the exception of use during voting and when a family visited a resident.</p> <p>2. Resident #41 was admitted to the facility on 2/27/18, with diagnoses including dementia and behavioral disorder.</p> <p>An admission MDS assessment, dated 3/6/18, documented Resident #41's activity preferences which were very important to her included having</p>	F 679			

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

PRINTED: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 679	<p>Continued From page 22</p> <p>books and magazines she liked, pet visits, group activities, participating in favorite activities, fresh air, and religious activities.</p> <p>A quarterly Activity Assessment, dated 12/3/18, documented Resident #41's activity preferences that were very important to her were listening to music, pet visits, family and friend visits, going to the beauty parlor, bingo, current events/news, western movies, outdoor time, religious services, socials/parties, and talking to others. The assessment documented it was somewhat important to her to read. The assessment documented Resident #41 used to enjoy arts and crafts, cooking demonstrations, gardening, puzzles/word games, and coloring. The assessment documented Resident #41 had no interest in board games, group discussions, and educational programs. The assessment documented staff offered coloring, word searches, and 1:1 conversation with staff.</p> <p>The Activities care plan, dated 2/27/18, documented Resident #4 enjoyed activities with music, walking outside, word searches, ice cream and cookies. The care plan did not include the interests identified as very important to her on the MDS or quarterly activities assessment and included some activities that Resident #41 had identified as a past interest on her care plan.</p> <p>Resident #41's Activities Flowsheet, dated 12/1/18 through 1/16/19, did not include documentation of pet visits, family and friend visits, going to the beauty parlor, bingo, current events/news, western movies, religious services, socials/parties, and talking to others. The flowsheets documented Resident #41</p>	F 679			

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

PRINTED: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 679	<p>Continued From page 23</p> <p>participated in a music activity on 12/7/18, 12/11/18, 12/14/18, 12/21/18, 12/22/18, and 12/28/18. The flowsheet documented she actively discussed the weather on 12/7/18, 12/14/18, 12/21/18, 12/28/18, 1/4/19, and 1/10/19. The flowsheet documented staff read to her on 1/4/19 and 1/10/19. Resident #41 had minimal participation in activities that were identified on her care plan and her activities were not individualized with her identified interests.</p> <p>On 1/14/19 from 12:17 PM to 2:15 PM, Resident #41 was observed sitting in the hallway with her back to the nurses' station and facing the back side of the TV. Resident #41 had a staff member standing next to her or sitting next to her periodically throughout the observation. Resident #41 was observed groaning and moaning when staff was not by her side, from 12:41 PM to 12:53 PM, at 1:04 PM and 1:06 PM, and from 1:11 PM to 1:43 PM.</p> <p>On 1/15/19 from 10:51 AM to 12:25 PM, Resident #41 was observed sitting with her back to the nurses' station and periodically staff sat next to her. Resident #41 was observed periodically moaning, groaning, and crying softly to herself.</p> <p>On 1/15/19 from 12:35 PM to 2:43 PM, Resident #41 was observed in bed with her eyes closed. Resident #41's TV was off, and no music was playing.</p> <p>On 1/15/19 from 4:32 PM to 5:32 PM, Resident #41 was observed sitting in her wheelchair with her back to the nurses' station and periodically crying and moaning.</p>	F 679			

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

PRINTED: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 679	<p>Continued From page 24</p> <p>On 1/15/19 at 5:36 PM, Resident #41 was assisted into bed.</p> <p>On 1/16/19 at 10:18 AM, Resident #41 was observed in bed and cried out, "Help, help, help."</p> <p>On 1/16/19 at 12:19 PM, Resident #41 was observed in her wheelchair with her back to the nurses' station and cried out, "Help, help, help, help, help."</p> <p>On 1/17/19 at 11:00 AM, Resident #41 was observed in her wheelchair with her back to the nurses' station moaning and crying, "Help, help, help, help, help."</p> <p>On 1/17/19 at 11:36 AM, the Activities Director stated Resident #41 spent most of her day at the nurses' station people watching. The Activities Director stated Resident #41 liked weather reports. The Activities Director stated Resident #41 appeared to have increased fear and she could benefit from 1:1 interaction and music playing. The Activities Director stated she had sensory stimulation books for residents with dementia and she encouraged staff to utilize these tools. The Activities Director stated Resident #41 may benefit from this type of sensory stimulation. The Activities Director stated she knew Resident #41's activities could be better suited to her current level of function.</p> <p>3. Resident #46 was admitted to the facility on 5/4/18, with diagnoses including dementia, difficulty in walking, muscle weakness, and repeated falls.</p> <p>An admission MDS assessment, dated 5/10/18,</p>	F 679			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 679	<p>Continued From page 25</p> <p>documented Resident #46's activity preferences that were very important to her were listening to music, pet visits, keeping up with the news, participating in favorite activities, and outside activities.</p> <p>A quarterly Activity Assessment, dated 12/11/18, documented Resident #46's activity preferences that were very important to her were listening to music, pet visits, family and friend visits, going to the beauty parlor, current events and news, educational programs, outdoor time, having conversation in person and on the phone, and watching the news or Dr. Oz. The assessment documented Resident #46 used to enjoy shopping, gardening, and arts and crafts. The assessment documented Resident #46 had no interest in computers, group discussions, puzzles and word games, the radio, socials/parties, and sports.</p> <p>The Activities care plan, dated 5/7/18, documented Resident #46 enjoyed daily guided walks in the facility, evening prayer with another resident, 1:1 visits with staff, a family member suggested offering gardening, organizing her belongings, having extra pudding and yogurt in her room, and going outdoors, which Resident #46 declined. The care plan did not include all the interests identified as very important to her on the MDS or quarterly activities assessment and included some activities that Resident #46 had identified as a past interest on her care plan.</p> <p>Resident #46's Activities Flowsheet, dated 12/1/18 through 1/16/19, did not include documentation of pet visits, listening to music, going to the beauty parlor, current events/news,</p>	F 679			

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

PRINTED: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 679	<p>Continued From page 26</p> <p>watching TV, and educational programs. The flowsheet documented Resident #46 participated in organizing her belongings and having extra yogurt and cookies in her room from 12/1/18 through 12/31/18. The flowsheet documented she was provided 1:1 visits on 12/4/18, 12/9/18, 12/16/18, 12/18/18, 12/27/18, 12/31/18, and 1/4/19. The activities flowsheet documented she was actively prayed with another resident each day from 12/1/18 to 1/16/19. The activities flowsheet documented Resident #46 participated in guided walks around the facility with Restorative nursing from 12/1/18 through 12/31/18. Resident #46 had minimal participation in activities that were identified on her care plan and her activities were not individualized with her identified interests.</p> <p>The care plan area addressing Resident #46's ROM Program, dated 6/29/18, documented two staff members were to ambulate with Resident #46 with her front wheeled walker for 25-200 feet.</p> <p>On 1/16/19 at 11:30 AM, the Activities Director stated she documented the walking program provided by restorative as guided walks. The Activities Director stated she was unaware the RNP for walking was not consistently provided to Resident #46.</p> <p>On 1/14/19 at 12:59 PM, Resident #46 was observed sleeping in a recliner chair in her room.</p> <p>On 1/14/19 at 2:14 PM, Resident #46 stated she wanted to walk around the facility and it was difficult at times to find two staff members for walking assistance.</p>	F 679			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 679	Continued From page 27 On 1/15/19 at 9:46 AM, Resident #46 was observed sitting in her recliner chair eating. Resident #46 was observed in the same position on 1/15/19 at 10:09 AM, 10:37 AM, 11:25 AM, 12:15 PM, 2:46 PM, and 4:37 PM. Resident #46 stated no one came to visit her unless she used her call light to request something. Throughout the observation period Resident #46's TV was off, and she slept periodically. On 1/16/19 at 10:12 AM, Resident #46 was observed tearful and crying and stated she did not understand why two staff members had to assist her with everything she did. Resident #46 stated if she wanted assistance with water two staff members entered her room to assist. Resident #46 stated she felt like staff did not want to help her or visit her because of this. On 1/16/19 at 11:30 AM, the Activities Director stated Resident #46's 1:1 visits should be completed one to two times a week. The Activities Director stated this was not done and Resident #46 required the assistance of two staff members with all cares. On 1/16/19 at 11:05 AM, the RSM stated Resident #46 had behavioral issues which included being accusatory towards staff. The RSM stated one of the identified practices used to keep Resident #46 safe, required two staff members assistance when physical contact was required. The RSM stated Resident #46 did not require the assistance of two staff members with all her needs. The RSM stated one staff member could complete a 1:1 visit for activities.	F 679			

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

PRINTED: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 679	Continued From page 28 On 1/17/19 at 11:51 AM, the Activities Director stated she stayed late on Mondays and Wednesdays to provide activities later into the day. The Activities Director stated she was aware the activities calendar did not have many activities after 5:00 PM and she was working on scheduling more activities. The Activities Director stated she did not have many night activities because residents went to bed early. The Activities Director stated there were two activities personnel for all residents. The Activities Director stated she could use more staff to assist with meeting the residents' activities needs.	F 679			
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a	F 688		4/1/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 688	<p>Continued From page 29</p> <p>reduction in mobility is demonstrably unavoidable.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, resident and staff interview, policy review, and record review, it was determined the facility failed to ensure residents received treatment and services to prevent further decrease in ROM. This was true for 5 of 6 residents (#18, #21, #41, #46, and #60) who were reviewed for treatment and services related to ROM. This deficient practice placed residents at increased risk of experiencing a decrease in mobility and function due to lack of AROM or passive ROM (PROM) services. Findings include:</p> <p>The facility's Restorative Nursing Services policy, revised April 2018, documented residents' restorative goals and objectives were individualized per their needs and outlined in their care plans.</p> <p>1. Resident #60 was admitted to the facility on 2/4/15, with diagnoses including dementia with behavioral disturbances, hemiplegia (paralysis) affecting the right side, and gout.</p> <p>A quarterly MDS assessment, dated 12/24/18, documented Resident #60 had moderate cognitive impairment and she required extensive assistance from one to two staff members with all cares. The MDS assessment documented Resident #60 received AROM two days, splint or brace placement four days, and walking program two days during the 7 day look back period.</p> <p>The care plan area addressing Resident #60's</p>	F 688	<p>Affected Residents It was noted that 5/6 residents did not receive RA services as scheduled. Resident #18, #21, #41, #46, and #60 who were reviewed for treatment and services related to ROM. This deficient practice placed residents at increased risk of experiencing a decrease in mobility and function due to lack of AROM or passive ROM (PROM) service.</p> <p>Corrective Action Staff schedules were changed to meet residents' needs and additional restorative staff will be hired as needed. When RA is unavailable will assign RA programs to mentor CNAs to be completed based off the schedule for that specific day.</p> <p>Nursing staff, Restorative Nurse, Restorative Aides, and Lead Mentor in-serviced by 3/29/2019 discussing the changes and expectations of the program.</p> <p>Staff member Systemic Changes Will assign specific RA aide to specific residents. Will also determine that the time allotted for RA meets needs of residents.</p> <p>Monitoring</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 688	<p>Continued From page 30</p> <p>AROM Program, dated 2/28/16, documented she was to participate in group activities with RNAs or activity aides 7 days a week for 15 minutes, or open gym from 3:30-4:30 PM.</p> <p>Resident #60's Restorative Program flowsheet, dated 12/1/18 through 1/16/19, documented RNA staff completed AROM for a minimum of 15 minutes on 12/18/18, 12/20/18, 1/1/19, and 1/5/19-1/8/19. Resident #60 did not receive AROM from the RNAs 40 days out of 47 days. The AROM/ROM flowsheets also documented CNAs completed an unknown amount of time of AROM for 34 days of the 47 days during the time frame.</p> <p>The care plan area addressing Resident #60's left hand brace, dated 4/17/18, documented staff provided gentle stretching of her third and fourth digit and applied a sheepskin palm protector to her left hand after washing her hands. The care plan documented the brace could be worn day and night and to replace the brace the next day if Resident #60 removed it.</p> <p>The Restorative Program flowsheet for Resident #60, dated 12/1/18 through 1/16/19 documented staff completed gentle stretching of her third and fourth digits and applied a sheepskin palm protector to her left hand on 12/2/18, 12/3/18, 12/5/18, 12/6/18, 12/9/18, 12/10/18, 12/12/18, 12/13/18, 12/18/18, 12/20/18, 12/23/18-12/25/18, 12/30/18-1/1/19, 1/4/19-1/9/19, 1/11/19, 1/12/19, 1/14/19, and 1/15/19. Resident #60 did not receive her left-hand brace 20 days out of 47. There was no documentation why the brace was not applied on the 20 days.</p>	F 688	<p>Audits will be done weekly RA nurse or designee for two months, every other week for two months, and then quarterly to ensure RA needs are meet. RA nurse will audit quarterly indefinitely Monthly meeting with RA program staff and discussion of accurate charting. Results of audits will be provided to Director of Nursing. Audits will be provided to DNS per audit schedule mentioned above Audits will be reported to the Q.A.P.I. committee monthly.</p> <p>Director of Nursing, and/or Designee are responsible for compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 688	<p>Continued From page 31</p> <p>The care plan area addressing Resident #60's ROM Program, dated 9/3/16, documented staff were to ambulate Resident #60 to the dining room and back to the hall three times daily, and from her room to the common room as needed with her front wheeled walker, six to seven days a week. The care plan directed the RNAs to document the total number of feet walked each day.</p> <p>Resident #60's Restorative Program flowsheet, dated 12/1/18 through 1/16/19, documented staff completed ambulation with Resident #60 on 12/2/18, 12/3/18, 12/5/18, 12/6/18, 12/9/18, 12/10/18, 12/12/18, 12/13/18, 12/18/18, 12/20/18, 12/23/18-12/27/18, 12/30/18/1/1/19, 1/3/19-1/9/19, 1/12/19, and 1/15/19. Resident #60 did not receive assistance with walking on 20 days out of 47.</p> <p>The Restorative Program flowsheet for Resident #60 documented Restorative Aides were not available on 12/1/18, 12/7/18, 12/18/18, 1/2/19, and 1/13/19, and documented restorative services were not offered to Resident #60 on 12/17/18 and 1/16/19.</p> <p>On 1/14/19 from 12:50 PM through 2:02 PM, Resident #60 was observed sitting near the nurses' station without a brace on her left hand. Resident #60 was observed again without her hand brace on 1/15/19 from 11:00 AM through 4:33 PM and on 1/16/19 at 9:00 AM through 2:14 PM.</p> <p>On 1/15/19 at 11:45 AM, Resident #60 was observed being wheeled into the dining room by staff for lunch.</p>	F 688			

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

PRINTED: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 688	<p>Continued From page 32</p> <p>On 1/15/19 at 5:28 PM Resident #60 was observed being assisted into her wheelchair and wheeled to the dining room for dinner.</p> <p>On 1/16/19 at 2:14 PM, RNA #2 stated Resident #60 had multiple programs and it was difficult to complete these daily. RNA #2 stated one of Resident #60's programs included a brace to her left hand. RNA #2 stated Resident #60 was to wear the brace before breakfast and keep it on as long as she could tolerate it. RNA #2 stated she knew Resident #60's brace was not always placed on her hand. RNA #2 stated on days when she did not have time to place the brace, she would document RA services were unavailable or not offered and document a zero for the time completed. RNA #2 stated she did not document how long Resident #60 wore her brace and did not know if the brace was effective or not. RNA #2 stated Resident #60 did not have her brace on 1/16/19, and RNA #2 did not have time to place it on her hand. RNA #2 stated on occasions Resident #60 participated in exercise programs or a CNA provided AROM with Resident #60 and RNA #2 stated she documented "CNA" on the ADL AROM/ROM flowsheet. RNA #2 stated she did not know how long CNAs worked with Resident #60 or everything they did. RNA #2 stated she sometimes saw CNAs "doing something" with Resident #60 and that was how she knew they had completed the AROM.</p> <p>On 1/16/19 at 2:45 PM, LPN #2 stated Resident #60 should wear the brace during the day for as long as possible or as tolerated. LPN #2 stated Resident #60 removed the brace herself or asked</p>	F 688			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 688	<p>Continued From page 33</p> <p>staff to remove it. She was unsure how long Resident #60 wore the brace or if it was effective because the RNP did not capture this information. LPN #2 stated she was unaware if Resident #60's walking program for meals was completed three times a day or not. LPN #2 stated the RNAs documented how many total feet Resident #60 walked for the day.</p> <p>On 1/16/19 at 3:20 PM, the Therapy Director stated Resident #60's hand brace should be on for 8 hours and off for 8 hours. The Therapy Director stated Resident #60's orders did not specify what type of brace to use or how long she required the brace. He stated Resident #60 needed a sheepskin brace.</p> <p>2. Resident #46 was admitted to the facility on 5/4/18, with diagnoses including dementia, difficulty in walking, muscle weakness, and repeat falls.</p> <p>A quarterly MDS assessment, dated 12/12/18, documented Resident #46 was cognitively intact and she required extensive assistance of one staff members with all cares except eating. The MDS assessment documented Resident #46 received AROM and restorative walking four days during the look back period of 7 days.</p> <p>The care plan area addressing Resident #46's ROM Program, dated 6/29/18, documented two staff members were to ambulate with Resident #46 with her front wheeled walker for 25-200 feet daily.</p> <p>Resident #46's Restorative Program flowsheet, dated 12/1/18 through 1/16/19, documented staff</p>	F 688			

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

PRINTED: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 688	<p>Continued From page 34</p> <p>completed her walking program of 25-200 feet on 12/2/18, 12/5/18, 12/6/18, 12/9/18-12/13/18, 12/16/18, 12/20/18, 12/23/18, 12/24/18, 12/26/18, 12/27/18, 12/30/18, 12/31/18, 1/3/19, 1/4/19, 1/6/19, and 1/10/19. Resident #46 did not receive her walking program 27 days out of 47.</p> <p>The care plan area addressing Resident #46's AROM, dated 6/29/18, documented she was to do AROM to her upper and lower extremities 7 days a week. The care plan documented the staff was to assist Resident #46 with AROM exercises of two to three sets of 10 repetitions for her knee and hip flexion, two to three sets of 10 repetitions to her ankle and shoulder, and 10 repetitions of trunk flexion and extension.</p> <p>Resident #46's Restorative Program flowsheet, dated 12/1/18 through 1/16/19, documented staff completed AROM to her upper and lower extremities on 12/2/18, 12/5/18, 12/6/18, 12/9/18-12/13/18, 12/16/18, 12/20/18, 12/23/18, 12/24/18, 12/26/18, 12/27/18, 12/30/18, 12/31/18, 1/3/19, 1/4/19, 1/6/19, 1/9/19, and 1/10/19. Resident #46 did not receive AROM 26 days out of 47.</p> <p>The Restorative Program flowsheet for Resident #46 documented Restorative Aides were not available on 12/1/18, 12/7/18, 12/8/18, 12/14/18, 12/15/18, 1/2/19, and 1/13/19, and documented restorative services were not offered to Resident #41 on 12/4/18, 12/17/18, 1/1/19, 1/5/19, 1/7/19, 1/8/19, 1/11/19, and 1/14/19.</p> <p>On 1/16/19 at 11:05 AM, the RSM stated Resident #46 had behavioral issues which included being accusatory towards staff. The</p>	F 688			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 688	<p>Continued From page 35</p> <p>RSM stated one of the identified practices used to keep Resident #46 safe included requiring two staff members to assist when physical contact was required.</p> <p>On 1/16/19 at 2:14 PM, RNA #2 stated Resident #46 had multiple programs and it was difficult to complete these daily. RNA #2 stated Resident #46 required two staff members for all her cares and this included the RNP because physical contact occurred. RNA #2 stated it was difficult to obtain a second person to complete Resident #46's RNP consistently. RNA #2 stated the RNAs were not scheduled to work at the same time and this meant she had to find a CNA to assist her or the RNP would not be completed.</p> <p>On 1/16/19 at 2:45 PM, LPN #2 stated Resident #46 required two staff members to complete her RNP due to behavioral issues and safety concerns.</p> <p>3. Resident #41 was admitted to the facility on 2/27/18, with diagnoses including dementia, behavioral disorder, adult failure to thrive, and rheumatoid arthritis.</p> <p>A quarterly MDS assessment, dated 12/3/18, documented Resident #41 was severely cognitively impaired and she required extensive assistance from one to two staff members with all cares. The MDS assessment documented Resident #41 received PROM five days during the look back period of 7 days.</p> <p>The care plan area addressing Resident #41's Restorative Program flowsheet, dated 9/19/18, documented staff were to provide her with gentle</p>	F 688			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 688	<p>Continued From page 36</p> <p>PROM to her joints for 15 minutes a day, six to seven days a week. The care plan did not document which joints staff were to provide the PROM to, how to perform the task, or document if they were to spend 15 minutes on each joint or take 15 minutes for all joints.</p> <p>Resident #41's Restorative Program flowsheet, dated 12/1/18 through 1/16/19, documented staff completed PROM for a minimum of 15 minutes on 12/2/18- 12/6/18, 12/9/18, 12/11/18, 12/12/18, 12/18/18, 12/20/18, 12/23/18, 12/26/18, 12/30/18-1/1/18, 1/3/19-1/6/19, 1/8/19, 1/9/19, 1/12/19, 1/15/19, and 1/16/19. Resident #41 did not receive PROM 20 days out of 47. The Restorative Program flowsheet for Resident #41 documented Restorative Aides were not available on 12/1/18, 12/7/18, 12/8/18, 12/14/18, 12/15/18, 1/2/19, and 1/13/19, and documented restorative services were not offered to Resident #41 on 12/17/18, 12/25/18, 1/7/19, and 1/14/19.</p> <p>On 1/16/19 at 2:04 PM, RNA #2 stated if Resident #41's RNP was completed in the morning she tolerated it better. RNA #2 stated Resident #41's RNP program did not specify what joints to provide the PROM to or for how long. RNA #2 stated LPN #2 knew more details about which joints the program dealt with for Resident #41.</p> <p>On 1/16/19 at 2:45 PM, LPN #2 stated PROM for Resident #41's upper and lower extremities should be completed daily. LPN #2 stated the current directions did not specify which joints to target and she would correct this.</p> <p>4. Resident #21 was admitted to the facility on</p>	F 688			

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

PRINTED: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 688	<p>Continued From page 37</p> <p>8/1/17, with multiple diagnoses which included stroke with left hemiplegia (paralysis).</p> <p>A quarterly MDS assessment, dated 10/26/18, documented Resident #21 was cognitively intact, required extensive assistance of one to two staff members for his ADLs and had impairment to one side of his upper and lower extremities.</p> <p>Resident #21's ROM care plan, dated 8/1/17, documented he was to receive passive ROM on his left upper and left lower extremities as he can tolerate and active ROM exercises on his right upper and right lower extremities.</p> <p>Resident #21's Restorative Program flowsheet, dated 12/1/18 through 1/16/19, documented staff completed his PROM on 12/2/18-12/6/18, 12/9/18-12/13/18, 12/16/18, 12/20/18, 12/23/18-12/27/18, 12/30/18, 12/31/18, 1/1/19, 1/3/19, 1/4/19, 1/6/19-1/12/19, 1/10/19, and 1/14/19-1/16/19. The flowsheet documented Resident #21 did not receive PROM on 15 days out of 47.</p> <p>The Restorative Program flowsheet documented Restorative Aides were not available on 12/1/18, 12/7/18, 12/8/18, 12/14/18, 12/15/18, and 1/13/19, and restorative services were not offered on 12/17/18 and 1/5/19.</p> <p>On 1/14/19 at 2:30 PM, Resident #21 said he received PT three times a week for his lower extremities. Resident #21 said he was not receiving PT for his upper left arm. When asked to move his left upper arm, Resident #21 said he could not move his left upper arm. Resident #21 then used his right hand to lift his left upper arm.</p>	F 688			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 688	<p>Continued From page 38</p> <p>Resident #21 said he wanted to have PT for his left upper extremity to make it stronger.</p> <p>On 1/16/19 at 12:24 PM, the Therapy Director said Resident #21 had a muscle strengthening program in the past and he "plateaued" (state of little or no change). Resident #21 was then referred to the RNP. The Therapy Director said if Resident #21 did not receive his restorative therapy consistently as ordered, he will have further decrease on his ROM and possible increase in pain to his left shoulder.</p> <p>On 1/16/19 at 2:20 PM, LPN #2 who was the RNP Supervisor confirmed Resident #21 did not receive his ROM exercises. LPN #2 said the facility needed three RNAs to meet the residents' ROM exercise/needs. LPN #2 said the facility had only one RNA during that time to do all the ROM exercises. LPN #2 said the facility recently hired a new RNA and was still looking for another one. LPN #2 also stated the RNAs were required to document on the back of the Restorative Program flowsheet the reason why ROM exercises were not performed.</p> <p>On 1/17/19, at 1:08 PM, RNA #2 said she was the only RNA in the facility and she was unable to meet the residents' ROM exercises/needs.</p> <p>5. Resident #18 was admitted to the facility on 4/9/15, with multiple diagnoses which included dementia.</p> <p>A quarterly MDS assessment, dated 10/19/18, documented Resident #18 was cognitively impaired and he required extensive assistance of two staff members for his activities of daily living.</p>	F 688			

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

PRINTED: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 688	<p>Continued From page 39</p> <p>The MDS assessment documented Resident #18 had impairment of his upper extremity on one side and both of his lower extremities.</p> <p>Resident #18's ROM care plan, dated 8/23/18, documented he was to receive passive ROM exercises 6-7 days a week, 15 minutes per day.</p> <p>Resident #18's Restorative Program flowsheet, dated 12/1/18 through 1/16/19, documented he received his passive ROM exercises on 12/2/18-12/4/18, 12/9/18-12/13/18, 12/20/18, 12/23/18-12/27/18, 12/30/18, 12/31/18, 1/1/19, 1/3/19, 1/4/19, 1/6/19-1/12/19, and 1/14/19-1/16/19. The flowsheet documented Resident #18 did not receive his restorative therapy on 15 days out of 47. The Restorative Program flowsheet documented restorative services were unavailable on 12/1/18, 12/7/18, 12/8/18, 12/14/18, 12/15/18, 1/2/19, and 1/13/19, and were not offered on 12/17/18 and 1/5/19.</p> <p>On 1/15/19 at 12:10 PM, Resident #18 was observed sitting in his Broda (tilting wheelchair) chair with his arms folded on his chest. CNA #2 asked Resident #2 to open his arms but Resident #18 just kept his arms on his chest. LPN #5 said she believed Resident #18 had participated in the RNP once a day, 5 days a week.</p> <p>On 1/15/19 at 2:47 PM, Resident #18 was observed in bed with his both upper arms folded on his chest.</p> <p>On 1/15/19 at 3:05 PM and 3:26 PM, Resident #18 was observed in the same position.</p> <p>On 1/16/19 at 2:20 PM, LPN #2 who was the</p>	F 688			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 688	<p>Continued From page 40</p> <p>Restorative Nursing Program Supervisor, said the facility needed 3 RNAs to meet the residents' ROM exercises/needs. LPN #2 there was only one RNA during that time to do all the ROM exercises. LPN #2 said the facility just hired a new RNA and was still looking for another one. LPN #2 also stated the RNAs were required to document at the back of the flow sheet the reason why a resident did not perform their ROM exercises.</p> <p>On 1/17/19, at 1:08 PM, RNA #2 said she was the only RNA in the facility and she was unable to meet the residents' ROM exercises/needs.</p> <p>On 1/16/19 at 2:04 PM, RNA #2 stated she was one of two RNAs currently employed by the facility and the facility needed a minimum of three RNAs to ensure all residents received their RNP. RNA #2 stated there were two shifts for the RNP a morning and an evening shift. RNA #2 stated residents should receive their RNP seven days a week and LPN #2, who was the restorative nurse, scheduled the RNAs and assisted in determining what residents required RNP and what their programs entailed. RNA #2 stated it was difficult to complete the current caseload of residents every day and not all residents received their RNP daily. RNA #2 stated there were currently 30 residents on her caseload and some residents had two to three programs each. RNA #2 stated the different programs included AROM, PROM, transfer programs, braces, exercises, and walking programs. RNA #2 stated when she was unable to complete a residents' RNP, she would document RA services unavailable or not offered and document a zero</p>	F 688			

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

PRINTED: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 688	Continued From page 41 for the time completed. RNA #2 stated sometimes she would see CNAs doing some sort of activity with a resident and she would count that as her restorative and documented "CNA" on the ADL ROM flowsheet. On 1/16/19 at 2:45 PM, LPN #2 stated currently the facility needed a minimum of three RNAs to complete residents' RNP. LPN #2 stated the facility was in the process of trying to obtain a third RNA. LPN #2 stated activities aides and CNAs provided an open gym activity where they use balls and balloons with residents and completed other exercise activities a few days a week. LPN #2 stated the RNA should not document what the CNAs and activities aides were providing for exercises. LPN #2 stated if CNAs or activities aides completed exercises they should document what and how long of an exercise they completed for the residents. LPN #2 stated she was unaware the RNAs were documenting CNA when other staff provided some type of activity. On 1/17/19 at 4:00 PM, the DNS stated she was unaware residents' RNP were not completed as scheduled. The DNS stated the facility was in the process of hiring more staff in general. The DNS stated the restorative aides were rarely pulled to work the floor. The DNS stated she was aware the RNP could utilize more staff.	F 688			
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		4/1/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 689	<p>Continued From page 42</p> <p>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, policy review, and record review, it was determined the facility failed to ensure adequate supervision of residents to prevent falls. This was true for 1 of 1 resident (Resident #163) who were reviewed for falls. Resident #163 was harmed when staff failed to provide adequate supervision while the resident was in her room when she fell and sustained a left eyebrow laceration which required suturing. Findings include:</p> <p>Resident #163 was admitted to the facility on 2/14/18 and readmitted on 3/20/18, with multiple diagnoses including dementia with behavioral disturbance.</p> <p>Resident #163's hospital record, dated 2/11/18, documented she was admitted to the hospital due to acute mental status changes, back pain, and an unwitnessed fall in her home. The hospital record also documented Resident #163 had numerous falls mostly non-injury over the last 2 years.</p> <p>Resident #163's quarterly MDS assessment, dated 5/22/18, documented she had severe cognitive impairment, required 1 assist with activities of daily living, and set-up for eating.</p> <p>A Fall Risk Evaluation, dated 3/10/18, 4/4/18, and 5/20/18, documented Resident #163 was at high risk for falls.</p>	F 689	<p>Affected Residents Resident #163 is no longer a resident at the facility. All residents assessed as a fall risk could be affected by this citation.</p> <p>Corrective Action A list of interventions will be distributed to staff members to ensure immediate interventions are put in place after a resident fall. The facility completed a new fall assessment (fall score) on all residents in the facility and updated the resident care plan as needed. A spreadsheet identifies fall interventions for each resident and their risk for falling. The DNS and/or unit managers will educate the resident and/or responsible party on the fall interventions put in place and discuss risk versus benefits for each intervention. All nursing staff will be educated the fall spreadsheet, interventions, and expectations to discover the root cause of the fall.</p> <p>Systematic Changes A baseline fall risk assessment will be conducted by the admitting nurse at admission, with appropriate interventions put in place immediately, quarterly, and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 689	<p>Continued From page 43</p> <p>A Potential for Falls/Fall Prevention care plan, dated 3/20/18, documented Resident #163 had impaired cognition, incontinent of bowel and bladder, and had history of falls. Interventions included in the care plan documented staff were to provide well fitting, non skid footwear, safety checks every 15-30 minutes, keep immediate environment free of obstacles, place call light within reach, fall risk assessment quarterly and when necessary for changes when clinically indicated, and do not leave the resident in room in wheel chair unattended.</p> <p>Resident #163's medication included the following:</p> <ul style="list-style-type: none"> *Lexapro 10 mg daily for depression. *Remeron 15 mg at bedtime for weight loss. <p>An Incident and Accident (I&A) report, dated 3/3/18 at 8:00 AM, documented Resident #163 experienced an unwitnessed fall in her bathroom with no injury. She was found sitting on her buttocks with her pants off and her incontinent brief to her knees.</p> <p>An I&A report, dated 3/15/18 at 10:05 AM, documented Resident #163 experienced an unwitnessed fall in her room with no injury. She was found sitting on the floor.</p> <p>An I&A report, dated 4/4/18 at 2:15 PM, documented Resident #163 experienced an unwitnessed fall in her room with no injury. She was found sitting on the floor. A CNA statement documented she was not aware Resident #163 was brought to her room after lunch and was left</p>	F 689	<p>as needed.</p> <p>Residents who are at risk for falls and their interventions will be assessed at least every 30 days by the unit manager to ensure that care planned interventions are appropriate.</p> <p>Facility leadership and/or designee(s) will audit the fall prevention spreadsheet to ensure care planned interventions are in place.</p> <p>Monitoring Audits will be completed weekly for two months, every other week for two months, and then quarterly to ensure any falls that happened in that time period had appropriate interventions in place. Unit Managers will report to DNS results of 30 day audits Audits will be reported to the Q.A.P.I. committee monthly. Director of Nursing, and/or Designee are responsible for compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 689	<p>Continued From page 44 unattended in her room.</p> <p>An I&A report, dated 4/26/18 at 5:50 PM, documented Resident #163 was just brought back to her room after dinner, when she self-transferred from her wheelchair to her chair and slid to the floor.</p> <p>A Nursing Note, dated 5/7/18, documented Resident #163 was walking on her own in the hallways.</p> <p>A Physician's order, dated 5/7/18, documented an order to discontinue Resident #163's Lexapro while she was on Remeron.</p> <p>A Nursing Note, dated 5/9/18, documented Resident #163 continued to be impulsive and she was found in the bathroom on her own.</p> <p>A Nursing Note, dated 5/12/18, documented Resident #163 was very worried about her husband's condition.</p> <p>A Physician's order, dated 5/15/18, documented Resident #163 to received Zanax 0.5 mg every 8 hours as needed for anxiety.</p> <p>A Nursing Note, dated 5/17/18 at 4:30 PM, documented Resident #163's representative requested the Zanax 0.5 mg to be given at a half the dose.</p> <p>A Physician's order, dated 5/17/18, documented Resident #163's Zanax was decreased to 0.25 mg every 8 hours as needed for anxiety.</p> <p>A Nursing Note, dated 5/17/18, documented</p>	F 689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 689	<p>Continued From page 45</p> <p>Resident #163 had no adverse effect with the Zanax. She did not have signs and symptoms of anxiety/depression with the passing of her husband.</p> <p>An I&A report, dated 5/18/18 at 5:00 AM, documented Resident #163 experienced an unwitnessed fall in her room. She was found on the floor and observed to have sustained a 4-5 centimeter laceration above her left eyebrow, 2 bruises on the left side of her neck, and a bruise on her left knee which was about 4 cm by 4 cm in size. A 2.5 cm by 2.5 cm abrasion was also noted in the middle of the bruise on her left knee. Resident #163 was sent to the hospital due to her laceration above her left eyebrow.</p> <p>A hospital report, dated 5/18/18, documented Resident #163 had dementia and had increased stress recently since her husband passed away. A 3 centimeter laceration on her left eyebrow was sutured.</p> <p>On 1/18/19 at 3:26 PM, the DNS said the facility stopped residents' safety checks every 15 to 30 minutes. The DNS said Resident #163 was placed on a Falling Star Program which included 30 minutes checks of the resident. The DNS stated all staff members completed the 30 minute checks but it might not have been documented. The DNS said Resident #163 should not have been left in her room unattended when she was up in her wheelchair. The DNS stated if Resident #163 was in her room, in her wheelchair, she did not know who watched her because the staff working would assist with needs like this. The DNS stated she would look for what interventions were in place for Resident #163 when Resident</p>	F 689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 689	Continued From page 46 #163 started to self transfer and attempted to take herself to the bathroom. The DNS stated the incident report where Resident #163 sustained a laceration from a fall documented Resident #163 was seen in her bed by nursing approximately 30-1 hour before. The DNS stated for high fall risk residents the facility should have implemented completing a bowel and bladder eval, when Resident #163 was found in the bathroom following falls, a physical therapy eval, her room moved closer to the nurses' station, and Resident #163 in line of sight in the common areas and in her room.	F 689			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents received respiratory care as ordered by a physician. This was true for 2 of 3 residents (#2 and #162) reviewed for oxygen therapy. This deficient practice had the potential	F 695	Affected Residents Physician order for Resident #162 oxygen was obtained. Physician order for Resident #2 oxygen parameters was obtained. All residents on oxygen could be affected	4/1/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 695	<p>Continued From page 47 for harm if residents received unnecessary, excessive, or insufficient oxygen to maintain stability. Findings include:</p> <p>1. Resident #162 was admitted to the facility on 8/9/18 and was readmitted on 12/27/18, with multiple diagnoses including aspiration pneumonia.</p> <p>A significant change in status MDS assessment, dated 1/3/19, documented Resident #162 was cognitively intact and required oxygen therapy.</p> <p>On 1/15/19 at 10:10 AM, Resident #162 was observed in her wheelchair in the Bistro (a multipurpose room) receiving oxygen via nasal cannula.</p> <p>On 1/16/19 at 10:18 AM, Resident #162 was observed sleeping in her bed receiving oxygen via nasal cannula. The flow rate of oxygen was at two liters per minute (LPM).</p> <p>Resident #162's record did not include a physician order for oxygen use.</p> <p>On 1/18/19 at 10:53 AM, RN #2 said Resident #162 was on oxygen therapy prior to her discharge to the hospital in December 2018. RN #2 said it was the nurse consultant who transcribed the physician's orders from the hospital and the orders should have been reviewed the following morning during their daily meeting and oxygen therapy should have been ordered.</p> <p>2. Resident #2 was admitted to the facility on 10/22/18, with multiple diagnoses including heart</p>	F 695	<p>by this citation</p> <p>Corrective Action A thorough audit will be done of all residents who are on oxygen to verify their oxygen orders are current, contain appropriate parameters and are appropriate for the resident.</p> <p>All nursing staff in-serviced and educated surrounding oxygen orders and oxygen parameters by 3/29/2019.</p> <p>Systemic Changes Quarterly audits will be done indefinitely for all residents on oxygen to assure current and appropriate orders are in place.</p> <p>Monitoring: Audits will be completed weekly for two months, every other week for two months, and then quarterly to ensure oxygen orders are correct. Audits will be reported to the Q.A.P.I. committee monthly. Director of Nursing, and/or Designee are responsible for compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 695	<p>Continued From page 48 failure.</p> <p>A physician order, dated 10/22/18, documented Resident #2 was to receive oxygen to maintain her oxygen saturation level at greater than 90%, but did not specify a flow meter paramater.</p> <p>On 1/14/19 at 1:23 PM, Resident #2 was observed sitting in her recliner with the nasal cannula on her lap. Resident #2 said she used oxygen most of the time but was unsure if she was using her oxygen correctly.</p> <p>On 1/15/19 at 12:45 PM, Resident #2 was observed in her recliner leaning forward receiving oxygen via nasal cannula at 2 LPM.</p> <p>On 1/16/19 at 8:43 AM, LPN #5 said Resident #2 received continuous oxygen.</p> <p>On 1/16/19 at 8:48 AM, CNA #2 entered Resident #2's room to check the resident's vital signs. CNA #2 said Resident #2 had her oxygen flowing from the oxygen concentrator at 3 LPM.</p> <p>On 1/16/19 at 2:06 PM, Resident #2 was sitting in her recliner wearin her nasal cannula.</p> <p>On 1/17/19 at 12:05 PM, Resident #2 was observed sleeping in bed and receiving oxygen via a nasal cannula.</p> <p>On 1/17/19 at 3:13 PM, Resident #2 was observed in her recliner receiving oxygen via nasal cannula at 3 LPM.</p> <p>On 1/17/19 at 3:47 PM, RN #2 reviewed Resident #2's physician's order and said the</p>	F 695			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 695	Continued From page 49 oxygen order did not have a parameter and it should have one. RN #2 and the Surveyor then went to Resident #2's room and checked her oxygen flow rate, and it was at three LPM. RN #2 said the evening shift nurse should not have adjusted the resident's oxygen flow rate.	F 695			
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, resident and staff interview, and record review, it was determined the facility failed to ensure a method for evaluating a residents pain level and the effectiveness of residents' pain management plans for 4 of 6 residents (#39, #41, #46, and #60) reviewed for pain. Resident #46 was harmed when the facility did not provide adequate pain management to allow the resident to bathe more than once a week or to eat in comfort. Resident #60 was harmed when she exhibited verbal and nonverbal expressions of pain. This failure created the potential for harm for residents (#39, #41) experienced ongoing severe pain or increased pain. Findings include: The Facility's Pain Assessment and Management policy, dated March 2015, documented pain management was defined as the process of alleviating a resident's pain to a level that was	F 697	Affected Residents Residents #39, #41, #46, and #60 were reassessed and care plans updated regarding pain management. All residents could be affected by this citation. Corrective Action All residents pain assessed, and care plans were implemented. The facility implemented a verbal and non-verbal pain scale. All staff in-service on 3/12/2019 will educate staff members on the new pain program and new non-pharmacological approaches to pain. Systemic Changes The nursing staff will assess pain upon	4/1/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 697	<p>Continued From page 50</p> <p>acceptable to the resident. The policy documented staff were to assess, recognize, and address residents' pain. The policy documented staff were to complete comprehensive pain assessments upon admission, quarterly, and as needed.</p> <p>1. Resident #46 was admitted to the facility on 5/4/18, with diagnoses including dementia, muscle weakness, Parkinson's disease, lower abdominal, elbow, shoulder, and back pain.</p> <p>A quarterly MDS assessment, dated 12/12/18, documented Resident #46 was cognitively intact and she required extensive assistance of one staff members with all cares except eating. The MDS documented Resident #46 had frequent pain ratings of eight, which affected her sleep and daily activities.</p> <p>Resident #46's record did not include a pain evaluation.</p> <p>Resident #46's physician orders included:</p> <ul style="list-style-type: none"> - Tylenol 650 mg tablet daily for back pain, ordered on 5/4/18. - Tylenol 650 mg tablet every four hours for pain PRN, ordered on 5/4/18. - Monitor for pain every shift and PRN and document on the pain flowsheet every shift, ordered on 11/29/18. <p>The care plan area addressing Resident #46's pain, dated 5/28/18, documented staff were to provide Resident #46 with pain medications as ordered and monitor for effectiveness.</p>	F 697	<p>admission, quarterly, annually, and as needed.</p> <p>The Medication Administration Record will be updated to include pain assessments every 4 hours vs pain assessment every shift. A pain management flow sheet at the front of the MAR will record the residents pain level (verbal or non-verbal).</p> <p>The facility now has pain carts that offer non-pharmacological interventions for the residents reporting pain. Care plans will be updated accordingly with resident's preferences.</p> <p>Monitoring: M.A.R. audits will be completed weekly for two months, every other week for two months, and then quarterly to ensure pain is well managed and monitored. Audits will be reported to the Q.A.P.I. committee monthly.</p> <p>Director of Nursing, and/or Designee are responsible for compliance.</p>		

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

PRINTED: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 697	<p>Continued From page 51</p> <p>Resident #46's MARs from 12/1/18 through 1/16/19, did not include documentation of daily pain ratings on a 1 to 10 scale or faces scale on 12/1/18 through 12/4/18, 12/6/18 through 12/30/18, 1/1/19, 1/2/19, 1/3/19, 1/5/19 through 1/9/19, and 1/12/19, 1/13/19.</p> <p>Resident #46's MARs from 12/1/18 through 1/16/19 documented she was administered her PRN Tylenol once on 12/4/18, 12/5/18, 12/7/18, 12/11/18 to 12/13/18, 12/17/18, 12/25/18, 12/29/18 to 12/31/18, 1/5/19, 1/6/19, 1/10/19 to 1/13/19, and 1/16/19, and twice on 1/2/19 to 1/4/19, and 1/7/19 to 1/9/19. The effectiveness of the PRN pain medication was not documented on 12/4/18, 12/5/18, 12/31/18, 1/2/19, 1/4/19, 1/7/19, 1/8/19, and 1/10/19.</p> <p>On 1/15/19 at 9:46 AM, Resident #46 was observed sitting in her recliner chair eating. Resident #46 was observed sitting in the same position on 1/15/19 at 10:09 AM, 10:37 AM, 11:25 AM, 12:15 AM, 2:46 PM, and 4:37 PM. Resident #46 stated no one visited her unless she used her call light to request something.</p> <p>On 1/15/19 at 10:19 AM, Resident #46 stated she had pain in her lower back and legs. Resident #46 stated her pain was usually around a seven and she wanted zero pain. Resident #46 stated she could only handle one shower a week because of her pain. Resident #46 stated staff provided pain medications when she asked for them.</p> <p>On 1/15/19 at 10:35 AM, LPN #4 was standing next to Resident #46 with her afternoon pills and Resident #46 asked LPN #4 for pain medication.</p>	F 697			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 697	<p>Continued From page 52</p> <p>LPN #4 stated she was going to add the pain medication to her afternoon pills and left the room. LPN #4 did not assess Resident #46's pain level before she left the room.</p> <p>On 1/15/19 at 10:36 AM, LPN #4 returned with Resident #46's medication and pain medication, Resident #46 asked LPN #4 how much Tylenol was in the cup and LPN #4 stated 650 mg which was ordered. Resident #46 asked if she could get more depending on the upper limit. LPN #4 stated she was going to check Resident #46's orders and discuss it with the doctor.</p> <p>On 1/16/19 at 10:12 AM, Resident #46 stated she was in too much pain to eat her food and started crying.</p> <p>On 1/17/19 at 12:53 PM, LPN #3 stated Resident #46 had extreme pain in her back and legs. LPN #3 stated she provided PRN pain medications when Resident #46 requested them. LPN #3 stated Resident #46 was able to verbalize her pain level. LPN #3 stated when a PRN pain medication was provided the staff documented the administration on the PRN pain flowsheet and assess the effectiveness in approximately 30 minutes.</p> <p>On 1/17/19 at 4:00 PM, the DNS was aware non-pharmacological interventions were not documented as completed when a resident was in pain and she was aware the efficacy of pain medications and residents' pain levels were not consistently documented. The DNS stated staff should document residents' pain levels on the PRN pain flowsheet for the scheduled and the PRN pain medication administrations. The DNS</p>	F 697			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 697	<p>Continued From page 53 stated the facility's quality assurance committee was currently revising and reviewing their pain management program.</p> <p>2. Resident #60 was admitted to the facility on 2/4/15, with diagnoses including dementia with behavioral disturbances, gout, pain, polyneuropathy (damage of multiple nerves), and hemiplegia (paralysis of one side).</p> <p>A Pain Evaluation, dated 6/9/17, documented Resident #60 had "lots" of pain and she was unable to verbalize a pain rating. The evaluation did not document an acceptable pain level for Resident #60. Resident #60 did not have a more recent pain evaluation in her record.</p> <p>A quarterly MDS assessment, dated 12/24/18, documented Resident #60 had a moderate cognitive impairment and she required extensive assistance from one to two staff members with all cares. The MDS documented Resident #60 had a constant pain rating of eight, which affected her sleep and daily activities.</p> <p>Resident #60's physician orders included:</p> <ul style="list-style-type: none"> - Tramadol (a narcotic pain medication) 50 mg 1 tablet every 6 hours PRN for pain, use a pain scale of zero to ten or the face scale to rate the pain, ordered on 2/4/15. - Tramadol 50 mg twice daily for pain, ordered on 10/27/15. - Monitor for pain every shift and PRN and document on the pain flowsheet every shift, ordered 11/29/18. <p>The care plan area addressing Resident #60's</p>	F 697			

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

PRINTED: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 697	<p>Continued From page 54</p> <p>Pain, dated 2/16/15, documented staff were to complete pain assessments on admission and quarterly. The care plan documented staff were to assess Resident #60 for signs and symptoms of pain every shift, provide pain medications as needed, and provide non-pharmacological interventions as needed.</p> <p>Resident #60's 12/1/18 through 1/16/19 MARs did not include documentation of her daily pain rating on a 1 to 10 scale, or a rating using the faces scale. The MARs documented Resident #60 received PRN Tramadol once on 12/7/18, 12/16/18, 12/19/18, 1/2/19, 1/3/19, 1/5/19 through 1/8/19, 1/10/19, 1/12/19, and 1/13/19, and twice on 1/4/19 and 1/15/19.</p> <p>The Pain Management flowsheets for December 2018 and January 2019 did not include daily documentation Resident #60's pain level was assessed. There was no documentation on 12/1/18 to 12/6/18, 12/8/18 to 12/11/18, 12/13/18 to 12/28/18, 12/30/18, 12/31/18, 1/2/19, 1/5/19, 1/8/19. The Pain Management flowsheets did not include the effectiveness of the PRN pain medication when it was given to Resident #60 on 12/19/18, 1/2/19, 1/4/19, 1/5/19, 1/6/19, 1/7/19, and 1/8/19.</p> <p>On 1/14/19 at 12:50 PM, Resident #60 was observed near the nurses' station sitting in her wheelchair with her back to the TV and her eyes were closed. Resident #60 was observed from 12:50 PM through 1:47 PM without changes until staff assisted her to the restroom and then into her bed. Resident #60 was observed saying, "Ow" and took a deep breath while CNA #7 assisted her into bed.</p>	F 697			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 697	Continued From page 55 On 1/15/19 at 4:33 PM, Resident #60 was observed sitting in her wheelchair and lifting her legs up in the air and saying, "Help, help, help, help." A staff member assisted her into a lounge chair. The MAR documented the resident was given pain medication at 5:15 PM. The resident was not medicated with her prn pain medication for 45 minutes. On 1/17/19 at 3:21 PM, Resident #60 was observed sitting in her wheelchair and lifting her legs up in the air and saying, "Help, help, help, help." LPN #3 assisted Resident #60 into a lounge chair. The MAR did not document that the resident received a PRN pain medication. On 1/17/19 at 12:59 PM, LPN #3 stated Resident #60's pain was mostly in her legs and she raised her legs when she was in pain and said, "help." LPN #3 stated Resident #60 was unable to verbalize what her pain level was, and staff knew her pain level from her facial expressions. LPN #3 stated if staff asked Resident #60 directly if she was in pain, Resident #60 said yes or no. On 1/17/19 at 3:56 PM, LPN #2 stated the unit managers completed residents' pain assessments quarterly with the MDSs. LPN #2 stated Resident #60's quarterly pain assessment was missed, and Resident #60 did not have a current assessment completed. LPN #2 stated Resident #60 verbalized when she was in pain. 3. Resident #41 was admitted to the facility on 2/27/18, with diagnoses including dementia, failure to thrive, and rheumatoid arthritis.	F 697			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 697	<p>Continued From page 56</p> <p>A Pain Evaluation, dated 9/3/18, documented Resident #41 did not have pain at the time of the evaluation, and she was unable to verbalize a pain rating. The evaluation did not document an acceptable pain level for Resident #41.</p> <p>A quarterly MDS assessment, dated 12/3/18, documented Resident #41 had a severe cognitive impairment and she required extensive assistance from one to two staff members with all cares. The MDS documented Resident #41 received PRN and scheduled pain medications.</p> <p>Resident #41's physician orders included:</p> <ul style="list-style-type: none"> - Tylenol one 500 mg tablet for a pain rating of one to five and two tablets for a pain rating of six to ten every four hours PRN for pain, ordered on 2/27/18. - Monitor for pain every shift and PRN and document on the pain flowsheet every shift, ordered on 11/29/18. <p>Resident #41's care plan did not include a section for pain or pain management.</p> <p>Resident #41's Pain Management flowsheets from 12/1/18 through 1/16/19, documented Resident #41's daily pain rating was not documented on 12/1/18 to 1/10/19, 1/12/19, and 1/14/19 to 1/16/19.</p> <p>Resident #41's 12/1/18 through 1/16/19 MAR documented she was administered her PRN pain medication Tylenol once on 12/3/18, 12/4/18, 12/7/18, 12/8/18, 12/14/18, 12/15/18, 12/16/18, 12/18/18, 12/25/18 through 12/27/18, 12/30/18, 1/2/19, 1/3/19, 1/9/19, 1/11/19, 1/13/19, 1/14/19,</p>	F 697			

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

PRINTED: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 697	<p>Continued From page 57 and 1/16/19, and twice on 12/10/18, 1/4/19, 1/8/19, 1/10/19, 1/12/19, and 1/15/19. The effectiveness of the PRN pain medication was not documented on the Pain Management flowsheet on 12/8/18, 12/14/18, 12/18/18, 12/25/18, 1/4/19, and 1/14/19.</p> <p>Resident #41's pain medication was not administered per her physician's orders as follows:</p> <ul style="list-style-type: none"> - On 12/4/18 a pain rating was not documented, and 1000 mg of Tylenol was administered. - On 12/10/18 at 7:00 AM, Resident #41's pain was rated at a seven and 500 mg of Tylenol was administered not 1000 mg as ordered. - On 12/14/18 a pain rating was not documented, Tylenol was documented as given but the dose was not documented. - On 12/15/18 a pain rating was not documented, and 1000 mg of Tylenol was administered. - On 12/16/18 at 7:30 PM, Resident #41's pain was rated at a seven and 500 mg of Tylenol was administered not 1000 mg as ordered. - On 12/18/18 a pain rating was not documented, and 1000 mg of Tylenol was administered. - On 12/25/18 a pain rating was not documented, and 1000 mg of Tylenol was administered. <p>On 1/14/19 from 12:17 PM to 2:15 PM, Resident #41 was observed sitting in the hallway with her back to the nurses' station. Resident #41 had a staff member near her periodically throughout the observation. Resident #41 was observed groaning and moaning when staff was not by her side, from 12:41 PM to 12:53 PM, at 1:04 PM and 1:06 PM, and from 1:11 PM to 1:43 PM.</p>	F 697			

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

PRINTED: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 697	<p>Continued From page 58</p> <p>On 1/15/19 from 10:51 AM to 12:25 PM, Resident #41 was observed sitting with her back to the nurses' station and periodically staff sat next to her. Resident #41 was observed periodically moaning, groaning, and crying softly to herself.</p> <p>On 1/15/19 from 4:32 PM to 5:32 PM, Resident #41 was observed sitting in her wheelchair with her back to the nurses' station and periodically crying and moaning.</p> <p>On 1/16/19 at 10:18 AM, Resident #41 was observed in bed and cried out, "Help, help, help."</p> <p>On 1/16/19 at 12:19 PM, Resident #41 was observed in her wheelchair with her back to the nurses' station and cried out, "Help, help, help, help, help."</p> <p>On 1/17/19 at 11:00 AM, Resident #41 was observed in her wheelchair with her back to the nurses' station moaning and crying, "Help, help, help, help, help."</p> <p>On 1/17/19 at 12:47 PM, LPN #3 stated Resident #41 moaned and cried often. LPN #3 stated when Resident #41's cried and moaned louder than normal staff thought she was in pain. LPN #3 stated if staff touched her and Resident #41 tensed up staff knew she was in pain. LPN #3 stated with Resident #41 staff utilized the facial pain rating scale. LPN #3 stated nurses were supposed to document residents' pain levels on the PRN pain management flowsheet.</p> <p>4. Resident #39 was admitted to the facility on 5/14/16, with diagnoses of chronic kidney disease, traumatic brain injury, bipolar disorder, and osteoarthritis.</p>	F 697			

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

PRINTED: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 697	<p>Continued From page 59</p> <p>Resident #39's physician orders included Tramadol to be administered four times a day as needed for chronic pain, ordered 2/5/18.</p> <p>A Physician's Progress Note, dated 6/4/18, documented Resident #39 reported lower back pain and difficulty walking. The progress note documented Resident #39 had chronic pain and was stable with current medications.</p> <p>An annual MDS assessment, dated 11/8/18, documented Resident #39 was cognitively intact. The MDS documented Resident #39 received both scheduled pain medication, and as needed pain medication. The MDS documented Resident #39 experienced almost constant pain with a pain level of five which affected her sleep and daily activities.</p> <p>The care plan area addressing Resident #39's Pain, dated 11/11/18, documented staff were to assess Resident #39 for signs and symptoms of pain every shift, provide pain medications as needed, and provide non-pharmacological interventions as needed (backrub, position change, environment change).</p> <p>Resident #39's 12/1/18 through 1/16/19 MAR, documented Resident #39 received PRN pain medication 49 times during the 47 day period. Resident #39's Pain Management Flowsheet for 12/1/18 through 1/16/19 did not include documentation the staff attempted alternative pain relief measures prior to administering pain medication to Resident #39.</p> <p>On 1/14/19 at 12:07 PM, Resident #39 stated</p>	F 697			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 697	Continued From page 60 she had frequent back pain, and added that the nurses do not offer any alternatives except the medication. On 1/16/19 at 11:58 AM, LPN #1 stated when the staff administer PRN pain medication, they are to document the pain medication administration on the resident's MAR. They are also to document the resident's pain level on the Pain Management Flowsheet. LPN #1 stated the staff are expected to try alternative pain relief measures prior to administering pain medication. LPN #1 confirmed Resident #39's documentation did not include the nurses attempted alternative pain relief measures prior to administering pain medication to Resident #39. On 1/16/19 at 2:34 PM, the DNS stated Resident #39's record did not include documentation the nurses attempted alternative pain relief measures prior to administering pain medication to Resident #39. The DNS stated she knew there was an issue with the staff not implementing alternative pain relief measures prior to administering PRN pain medications.	F 697			
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure medication error rate was less than 5%.	F 759	Affected Residents All residents could be affected by this citation.	4/1/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 759	<p>Continued From page 61</p> <p>This was true for 2 of 30 medications (6.67%) which affected 2 of 6 residents (#6 and #45) whose medication administration was observed during medication pass. This failed practice placed residents at risk of not receiving medications as ordered by the physician and had the potential to lessen the effectiveness of the medications administered. Findings include:</p> <p>1. On 1/16/19 at 3:15 PM, RN #1 was observed applying triamcinolone cream 0.1% to Resident #45's bilateral cheeks (face) and bridge of her nose.</p> <p>Resident #45's record included physician orders for hydrocortisone cream 1% to cheeks twice a day and triamcinolone cream 0.1% to ankle rash twice a day.</p> <p>The pharmacy label on the triamcinolone documented the medication was to be applied to Resident #45's ankle twice a day.</p> <p>After the triamcinolone cream was applied to Resident #45's face RN #1 reviewed the label. RN #1 reread the triamcinolone label and then looked through several tubes of medication in her medication cart. RN #1 stated the triamcinolone was the same as the hydrocortisone cream and the triamcinolone was what they were using.</p> <p>On 1/18/19 at 12:55 PM, the Pharmacist said during a telephone interview, triamcinolone and hydrocortisone were not the same. The Pharmacist said they were both corticosteroids but triamcinolone was more potent and they were not interchangeable.</p>	F 759	<p>Corrective Action Nursing staff made immediately aware of medication error. Nursing staff re-educated and competence assessed about the 5 Rights of Medication Pass. Larger cups ordered to ensure that the accurate amount of fluid is used for diluting medications</p> <p>The DNS and/or designee will complete a medication pass audit on all Licensed Nurses.</p> <p>Systemic Changes Medication pass audits will be done quarterly by DNS indefinitely.</p> <p>Monitoring: Medication pass audits will be done weekly for two months, every other week for two months, and then monthly. Director of Nursing, and/or Designee are responsible for compliance</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 759	Continued From page 62 2. On 1/17/19 at 11:50 AM, LPN #4 was observed to administered ten oral medications to Resident #6, including Clearlax powder (a laxative) 17 grams mixed in a small amount of water. LPN #4 reviewed Resident #6's Clearlax order after administering it. LPN #4 read the order and said the Clearlax was to be mixed in four to six ounces of fluid but she had mixed it in less than four ounces of water.	F 759			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §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. §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	F 761		4/1/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/18/2019
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 63 and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure pharmacy labels matched the physician's order. This was true for 1 of 30 medications for 1 of 6 residents (Resident #6) whose medication passes were observed. The failure created the potential for Resident #6 to receive a wrong dose and experience an adverse effect. Findings include:</p> <p>Resident #6 was admitted to the facility on 4/17/17, with multiple diagnoses including epilepsy (seizure disorder).</p> <p>Resident #6's physician orders included depakote (an anti-seizure medication) 500 mg twice a day for mood disorder with depression, ordered on 7/6/18.</p> <p>On 1/17/19 at 11:50 AM, LPN #4 was observed administering 10 oral medications to Resident #6, including depakote 500 mg. The pharmacy label for the depakote documented "take one tablet by mouth every morning and take two tablets by mouth at bedtime (2 tabs = 1000 mg)."</p> <p>On 1/17/19 at 12:05 PM, RN #2 reviewed Resident #6's physician order for depakote and said it did not match the pharmacy label. RN #2 said they had informed the pharmacist about Resident #6's depakote order the last time they sent the medication. RN #2 said she will notify the pharmacy again.</p>	F 761	<p>Affected Residents It was determined the facility failed to ensure pharmacy labels matched the physician's order. This was true for resident #6</p> <p>Corrective Action A new medication card with the proper dosing was obtained from the pharmacy.</p> <p>Systemic Changes New medication card(s) will be obtained when a physician's order is changed for medications.</p> <p>Monitoring: Weekly audits for two months, every other week for two months, and then monthly to assure consistency and proper pharmacy labeling is maintained.</p> <p>Director of Nursing, and/or Designee are responsible for compliance</p>		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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

June 12, 2019

Charles Lloyd, Administrator
Valley Vista Care Center Of St Maries
820 Elm Street,
St Maries, ID 83861-2119

Provider #: 135075

Dear Mr. Lloyd:

On **January 14, 2019** through **January 18, 2019**, an unannounced on-site complaint survey was conducted at Valley Vista Care Center of St. Maries. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007851

ALLEGATION:

The facility was understaffed.

FINDINGS:

Fifteen residents were observed and their records were reviewed for Quality of Care and falls. The facility's staffing schedule, Incidents and Accident report, Resident Council minutes and Grievances file were reviewed. Residents, family and staff were also interviewed.

During observations of residents and staff members interacting, no concerns were identified. The residents' call lights were answered timely, assistance with Activities of Daily Living (ADL) were provided, hydration was offered, activities were offered, and other cares were offered and provided by staff.

Charles Lloyd, Administrator
June 12, 2019
Page 2 of 2

Resident Council Meeting minutes and Grievances from March 2018 to May 2018 documented staffing was an issue. The Resident Council meeting minutes and Grievances from November 2018 to January 2019, documented staffing was no longer an issue and the facility had corrected the concern.

Several residents and two family members said staffing numbers were better and the number of staff currently in the building met their needs. Residents stated a few months ago there was not enough staff to meet their needs and things like showers were infrequent, call light wait times were long, and ADL assistance was hard to come by. The residents stated the facility had hired new staff to provide cares and it was helping to meet their needs. CNAs and nurses said the staff numbers were better and they had more time to spend with the residents to ensure their needs were met.

The Director of Nursing Services and the Executive Director said the facility had hired more staff and were still trying to hire more. The Director of Nursing Services stated the staff were meeting residents' needs.

Based on the investigative findings, the allegation was substantiated but no deficient practice was cited due to the facility correcting the concerns prior to the survey.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

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,



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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

June 20, 2019

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

Provider #: 135075

Dear Mr. Lloyd:

On **January 18, 2019**, an unannounced on-site complaint survey was conducted at Valley Vista Care Center of St Maries. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007837

ALLEGATION #1:

A resident fell in her room and sustained an injury.

FINDINGS #1:

An unannounced onsite recertification and complaint survey was conducted on 1/14/19 through 1/18/19. Observations were conducted, three resident records were reviewed for Quality of Care and falls. The facility's staffing schedule, Incident and Accident reports, Resident Council minutes, and Grievance file were reviewed. Residents and family were interviewed, and staff was also interviewed.

One of three resident records documented concerns with accidents and/or falls.

One resident's record documented the resident was admitted in 2/2018 and readmitted in 3/2018,

and experienced five falls between 3/3/18 and 5/18/18. The facility failed to implement care plan interventions to keep the resident safe. The facility did not update the care plan after two of the falls.

The Director of Nursing Services (DNS) stated the facility stopped resident safety checks every 15 to 30 minutes. The DNS said the resident was placed on a Falling Star Program which included 30 minute checks of the resident. The DNS stated staff members completed the 30 minute checks but it might not have been documented. The DNS said the resident should not have been left in her room unattended when she was up in her wheelchair. The DNS stated she would look for what interventions were in place for the resident when she started to self transfer and attempted to take herself to the bathroom. The DNS stated the incident report where she sustained a laceration from a fall documented the resident was seen in her bed by nursing approximately 30 minutes to an hour before. The DNS stated for high fall risk residents the facility should have completed a bowel and bladder evaluation when the resident was found in the bathroom following falls. The DNS stated a physical therapy evaluation should have been completed, the resident should have been moved closer to the nurses' station, and she should be in line of sight in the common areas and in her room.

CONCLUSIONS:

Based on the results of the investigation, the allegation was substantiated, and a deficiency was cited at F689 as it relates to the failure of the facility to ensure high fall risk residents' care plan interventions were followed.

ALLEGATION #2

The facility was understaffed.

FINDINGS #2:

During the investigation residents were observed for quality of care and staffing concerns. Resident Council Meeting minutes were reviewed, facility grievances were reviewed, staff were interviewed, and residents and family members were interviewed regarding staffing.

During observations of residents and staff members interacting, no concerns were identified. The residents' call lights were answered timely, assistance with Activities of Daily Living (ADL) were provided, hydration was offered, activities were offered, and other cares were offered and provided by staff.

Resident Council Meeting minutes and Grievances from March 2018 to May 2018 documented staffing was an issue. The Resident Council Meeting minutes and grievances from November

Charles Lloyd, Administrator
June 20, 2019
Page 3

2018 to January 2019 documented staffing was not an issue and the facility had corrected the concern.

Several residents and two family members said staffing numbers were better and the number of staff currently in the building met their needs. Residents stated a few months ago there was not enough staff to meet their needs and things like showers were infrequent, call light wait times were long, and ADL assistance was hard to come by. The residents stated the facility had hired new staff to provide cares and it was helping to meet their needs. CNAs and nurses said the staff numbers were better and they had more time to spend with the residents to ensure their needs were met.

The DNS and the Executive Director said the facility had hired more staff and were still trying to hire more. The DNS stated the staff were meeting residents' needs.

CONCLUSIONS:

Based on the investigative findings, the allegation was substantiated but no deficient practice was cited due the facility correcting the concerns prior to the survey.

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 Deficiencies and Plan of Correction forms. One of the allegations was substantiated, but not cited. 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,



LAURA THOMPSON, RN, Supervisor
Long Term Care Program

Charles Lloyd, Administrator
June 20, 2019
Page 4

LT/slj