IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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March 3, 2020

Randal Barnes, Administrator
Valley Vista Care Center of St. Maries
820 Elm Street
St. Maries, ID 83861-2119

Provider #: 135075

Dear Mr. Barnes:

On **February 27, 2020**, 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 13, 2020**. Failure to submit an acceptable PoC by **March 13, 2020**, may result in the imposition of penalties by **April 5, 2020**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;

- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and

- Include dates when corrective action will be completed in column (X5).

  If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **April 2, 2020 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **May 27, 2020**. A change in the seriousness of the deficiencies on **April 12, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by
May 27, 2020 includes the following:

Denial of payment for new admissions effective **May 27, 2020**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 27, 2020**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Belinda Day, RN or Laura Thompson, RN, Supervisors Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **May 27, 2020** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

  2001-10 Long Term Care Informal Dispute Resolution Process
  2001-10 IDR Request Form

This request must be received by **March 13, 2020**. If your request for informal dispute resolution is received after **March 13, 2020**, 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 Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,

Laura Thompson, RN, Supervisor
Long Term Care Program

lt/lj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135075		C 02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VISTA CARE CENTER OF ST MARIES	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	INITIAL COMMENTS The following deficiency was cited during a complaint survey conducted from February 25, 2020 through February 27, 2020. The survey was conducted by: Monica Meister, QIDP, MEd, Team Coordinator Jenny Walker, RN Kim Saccomando, RN Survey Abbreviations: CNA - Certified Nurse Assistant COPD - Chronic Obstructive Pulmonary Disease. DON - Director of Nursing LPN - Licensed Practical Nurse NA - Nurse Aid RN - Registered Nurse	F 000		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	F 600		3/6/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/06/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 600	Continued From page 1 by: Based on review of facility reportable incidents and investigations, policy review, record review, and staff interview, it was determined the facility failed to ensure residents were free from abuse for 4 of 6 residents (Residents #1, #2, #4 and #5) whose reportable incidents and records were reviewed. This resulted in residents being subjected to ongoing abuse. The findings include: The facility's Abuse Prohibition policy, undated, stated the facility's policy prohibited abuse and neglect to all residents at the facility. The policy included the following definitions: - Abuse: "the [sic] willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes deprivation by an individual, including a caretaker, of goods and services that are necessary to attain or maintain physical, mental, and psychosocial well-being." - Mental abuse: "Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation." - Verbal abuse: "Verbal Abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability."	F 600	This Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because the provisions of the federal and state law require it. This provider maintains that the alleged deficiencies do not individually, or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit this providers capacity to render adequate resident care. Furthermore, the provider asserts that it is in substantial compliance with regulations governing the operation and licensure of long term facilities, and this Plan of Correction, in its entirety, constitutes this providers alleged compliance. Completion dates are provided for the procedural procession purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in compliance with requirements of participation or that corrective action was necessary. F600 Resident Specific: Resident #1: CNA #1 was suspended while incident was under investigation.	

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F 600	Continued From page 2 Residents #1, #2, #4, and #5 were subjected to abuse, as follows: a. Resident #1's record documented he was readmitted to the facility on 8/22/19, and his diagnoses included Parkinson's disease (progressive movement disorder), dementia without behavioral disturbance, dysphagia (difficulty swallowing), congestive heart failure (weakness of the heart leading to a buildup of fluid in the body), COPD (progressive lung disease characterized by increasing breathlessness), and anxiety disorder. Resident #1's record documented he had moderately impaired cognition as of 1/15/20. An investigation was submitted to the State Agency on 2/7/20 and documented Resident #1 was verbally abused. The investigation stated on 2/7/20, the DON received a voicemail from a staff member who reported she was walking through the common area when Resident #1's spouse stated, "[Resident #1] is being abused, and we have it on video tape and witness [sic]." The investigation documented the DON called the Administrator, who stated he would call Resident #1's spouse and speak with her or come to the facility if the spouse was still at the facility. The Administrator spoke with the spouse on the phone. The spouse stated the issue was with CNA #1 and she was in his room "raising cain [sic] and cursing." CNA #1 was placed on administrative leave at that time and the Administrator set up a conference with the family to be held on 2/10/20. The investigation documented that on 2/10/20,	F 600	After the meeting on 2-10-2020 with the family and more information was released to facility CNA #2 & #3 were also suspended during investigation. When facility received the video on 2-12-2020 and additional NA (nurses aide NA#1) was seen in the videos. All 4 were then terminated by the facility on 2-13-2020. Resident #2: CNA #4 was suspended for verbal abuse. As a result of the investigation through interviews of witnesses and accused, CNA #4 was terminated. Resident #4 & #5: A corrected report was submitted with the unsubstantiated correctly changed to substantiated. Other Residents: All residents have the potential to be affected by this deficient practice. Other residents residing in the facility were interviewed by the Resident Service Coordinators to determine if there were more issues not reported. All families were also contacted to ascertain if there were more issues not reported. If applicable, other reportables were placed in the portal for reporting alleged abuse accusations and were investigated according to facility policy and procedure. Systemic Changes: All staff were retrained on abuse reporting and prevention procedures starting on 2-13-2020. Another all staff training was held on 2-26-2020 including abuse	

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F 600	Continued From page 3 the facility's management staff met with Resident #1's family and Resident #1's spouse stated CNA #2 was the "ringleader" and reported that on 2/2/20, CNA #2 and CNA #3 lied about toileting Resident #1. The family reported that they (CNA #2 and #3) were also "rough handling" him when they put him to bed the night of 2/2/20. Resident #1's family stated they originally placed a camera in Resident #1's room, to watch Resident #1 but found out it was much more. The investigation documented the Administrator and DON requested they be shown the videos and CNA #2 and CNA #3 were put on administrative leave. The video was given to the facility by Resident #1's family on 2/12/20. The video showed Resident #1 was verbally abused by CNA #2. The video showed CNA #1, CNA #3 and NA #1 were in the room and witnessed the abuse. CNA #1, CNA #3 and NA #1 did not protect Resident #1 and report the verbal abuse to facility administration. The investigation documented the employment of CNAs #1- #3 and NA #1 was terminated and all staff attended a mandatory in-service on abuse and neglect. The local Ombudsman was notified by administration and came into the facility. The Ombudsman interviewed all of the residents as well as in-serviced all staff on mandatory reporting requirements. The investigation also documented all residents' families were interviewed. b. Resident #2's record documented she was admitted to the facility on 3/27/19, and her diagnoses included dementia with behavioral disturbance, hypertension, heart failure, and	F 600	prevention and reporting protocols. A second nurse was added to night shift to assist in supervision during night shift. Facility has also initiated a compliance hotline, staff can call this number 24-7 with immediate compliance issue forwarded to CEO, Compliance Officer and Director of Administrative Services. Monitoring: Department Managers will come in randomly during all shifts to watch and listen for appropriate interactions between residents and staff. This will happen bi-weekly for two months, then weekly for two months. Monthly training on abuse prevention and reporting with comptetencies. Reports of random visits to be reviewed at monthly QAPI meetings.	

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F 600	Continued From page 4 COPD. An investigation was submitted to the State Agency on 2/26/20, which documented on 1/15/20, Resident #2 was verbally abused by CNA #4. The investigation documented CNA #4 was interviewed and stated Resident #2 "started yelling about us and our parents. I asked her not to say those things as they are not nice. I raised my voice a little to her." The investigation documented that another CNA was interviewed and stated "[Resident #2] was noticed trying to get out of bed. [CNA #4] and I changed her brief and got her dressed and up ion [sic] her wheelchair. We took her to the common area and called for [another CNA] to come sit with her. They have a good rapport. At this point [Resident #2] started saying "this one is stupid and her mother is stupid too. Referring to [CNA #4] [sic]. [CNA #4] responded saying [Resident #2] needed not to talk about her or her mother. [CNA #4] then told [Resident #2] she was going to report her for her behaviors." The investigation stated Resident #2 was interviewed and stated "I get could [sic] care and I do not know most of their names. There was one girl last night that 'talks snarky.' She thinks she knows everything and thinks I am going to do things she says." The Conclusion section of the investigation stated, "Abuse substantiated. Through interviews of staff and residents, it was determined that [CNA #4] was arguing back and forth and during this she was verbally abusive to [Resident #2]." CNA #4's employment was terminated.	F 600		

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F 600	Continued From page 5 c. Resident #4's record documented she was readmitted to the facility on 1/11/20 and her diagnoses included Alzheimer's disease, dementia with behavioral disturbance, and anxiety disorder. Resident #4's record documented she had moderately impaired cognition as of 1/15/20. Her care plan, initiated 1/7/20, stated she required 1:1 staff when out of bed as she was at risk for falls. Resident #5's record documented she was admitted to the facility on 8/7/19, and her diagnoses included Alzheimer's disease, dementia with behavioral disturbance, and anxiety disorder. An investigation was submitted to the State Agency on 2/16/20, which documented Resident #4 and Resident #5 physically abused each other on 2/16/20. The investigation documented that Resident #4 was sitting at the table in the dining room and hit Resident #5 on the right hand. Resident #5 then slapped Resident #4 on her right cheek, resulting in redness without swelling. Both residents were separated immediately. The investigation stated CNA #5 was interviewed and stated "I was walking with [Resident #4]... [Resident #4] must have got tired and wanted to sit down. [Resident #5] was sitting in her wheelchair next to the table. As [Resident #4] was sitting down she grabbed the handgrips on [Resident #5's] wheelchair. I stated to [Resident #4] to grab my hand not the wheelchair. When [Resident #4] was seated (5 seconds) she slapped [Resident #5] on the right hand. [Resident #5] then in turn slapped [Resident #4]	F 600		

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F 600	Continued From page 6 on the right cheek. [Resident #4's] cheek had some redness initially, but it was gone by the end of our shift. I stepped between the two to separate them." The investigation stated the RN was interviewed and reported Resident #4 was sitting at the table in the dining room and hit Resident #5 on the right hand. Resident #5 then slapped Resident #4 on her right cheek. The RN stated redness was noted to Resident #4's right cheek but no swelling and no signs or symptoms of pain were noted. The RN stated the residents were separated. The investigation stated both residents were interviewed and did not remember the incident. The Conclusion section of the investigation stated "Resident to Resident abuse unsubstantiated. Redness to cheek gone the following day." When asked, the Administrator stated on 2/27/20 at 10:27 AM, physical abuse was substantiated and the word "unsubstantiated" in the investigation was "a typo." Another investigation was submitted to the State Agency on 2/18/20, which documented Resident #4 was physically abused by Resident #5 on 2/18/20. The investigation documented that CNA #6 was walking with Resident #4 when Resident #4 attempted to throw her can of V8 juice. Resident #4 continued walking and was close to Resident #5 who was sitting in the dining room. Resident #5 reached out and grabbed Resident #4's left wrist and squeezed it "with a menacing look." CNA #6 turned after catching the V8 can	F 600		

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F 600	Continued From page 7 and saw the interaction between the residents. CNA #6 then placed herself between the residents. The investigation stated the LPN was interviewed and reported CNA #6 was walking with Resident #4 for 1:1 care and Resident #4 attempted to throw her V8 can. Resident #4 continued walking, close to Resident #5, and Resident #5 reached out and grabbed Resident #4's left wrist and squeezed. CNA #6 turned after catching the V8 can and saw the interaction between the residents, and then placed herself between them. The LPN stated no injuries were noted. The investigation stated both residents were interviewed. Resident #4 did not respond to questions and Resident #5 stated that it could not have been her, because "she was not here until today." The Conclusion section of the investigation stated, "Resident to Resident abuse unsubstantiated." When asked, the Administrator stated on 2/27/20 at 10:27 AM, physical abuse was substantiated and the word "unsubstantiated" in the investigation was "a typo." The Administrator further stated the facility had "zero tolerance" for abuse and the abuse policy was to be implemented and followed by all staff. The facility failed to ensure Residents #1, #2, #4 and #5 were free from abuse.	F 600		

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E-mail: fsb@dhw.idaho.gov

March 24, 2020

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

Provider #: 135075

Dear Mr. Barnes:

On **February 25, 2020** through **February 27, 2020**, 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 #ID00008385

Allegation: Residents are not free from abuse and neglect.

Findings: During the survey, facility policy and resident records were reviewed and staff interviews were conducted with the following results:

The facility's Abuse Prohibition policy, undated, stated the facility's policy prohibited abuse and neglect to all residents at the facility. The policy included the following definitions:

- Abuse: "the {sic} willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes deprivation by an individual, including a caretaker, of goods and services that are necessary to attain or maintain physical, mental, and psychosocial well-being."

- Mental abuse: "Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation."

- Verbal abuse: "Verbal Abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability."

The facility's records included 4 investigations which documented 4 residents had been subjected to abuse, as follows:

1. An investigation was submitted to the State Agency on 2/7/20 and documented a resident was verbally abused. The investigation stated on 2/7/2020, the Director of Nursing (DON) received a voicemail from a staff member who reported she was walking through the common area when the resident's spouse stated, "{Resident's name} is being abused, and we have it on video tape and witness {sic}."

The investigation documented the DON called the Administrator, who stated he would call the resident's spouse and speak with her or come to facility if the spouse was still at the facility. The Administrator spoke with the spouse on the phone. The spouse stated the issue was with a Certified Nurse Assistant (CNA) and she was in his room "raising cain {sic} and cursing." The CNA was placed on administrative leave at that time and the Administrator set up a conference with the family to be held on 2/10/20.

The investigation documented that on 2/10/20, the facility's management staff met with the resident's family and the resident's spouse stated another CNA was the "ringleader" and reported on 2/2/20, the CNA identified by the resident's spouse as the "ringleader" and another CNA lied about toileting the resident. The family reported that the 2 CNAs were also "rough handling" the resident when they put him to bed the night of 2/2/20. The resident's family stated they originally placed a camera in the resident's room, to watch the resident but found out it was much more.

The investigation documented the Administrator and DON requested they be shown the videos and the 2 CNAs were put on administrative leave. The video was given to the facility by the resident's family on 2/12/20. The video showed the resident was verbally abused by the CNA identified by the resident's spouse as the "ringleader." The video showed 2 other CNAs and a nursing assistant were in the room and witnessed the abuse. The 2 other CNAs and a nursing assistant did not protect the resident and report the verbal abuse to facility administration.

The investigation documented the employment of the 3 CNAs and the nursing assistant was terminated and all staff attended a mandatory in-service on abuse and neglect. The local Ombudsman was notified and came into the facility. The Ombudsman interviewed all of the residents as well as in-serviced all staff on mandatory reporting requirements. The investigation documented that all residents' families were interviewed.

2. An investigation was submitted to the State Agency on 2/26/20, which documented on 1/15/20, a resident was verbally abused by a CNA. The investigation documented the CNA was interviewed and stated the resident "started yelling about us and our parents. I asked her not to say those things as they are not nice. I raised my voice a little to her."

The investigation documented another CNA was interviewed and stated "{Resident's name} was noticed trying to get out of bed. {A second CNA} and I changed her brief and got her dressed and up ion {sic} her wheelchair. We took her to the common area and called for {a third CNA} to come sit with her. They have a good rapport. At this point {Resident's name} started saying "this one is stupid and her mother is stupid too. Referring to {the second CNA} {sic}. {The second CNA} responded saying {Resident's name} needed not to talk about her or her mother. {The second CNA} then told {Resident's name} she was going to report her for her behaviors."

The investigation stated the resident was interviewed and stated "I get could {sic} care and I do not know most of their names. There was one girl last night that 'talks snarky.' She thinks she knows everything and thinks I am going to do things she says."

The conclusion section of the investigation stated, "Abuse substantiated. Through interviews of staff and residents, it was determined that {the second CNA} was arguing back and forth and during this she was verbally abusive to {Resident's name}." The second CNA's employment was terminated.

3. An investigation was submitted to the State Agency on 2/16/20, which documented 2 residents had physically abused each other on 2/16/20. The investigation documented a resident was sitting at the table in the dining room and hit another resident on the right hand. The resident who was hit on the right hand, then slapped the other resident on her right cheek, resulting in redness without swelling. Both residents were separated immediately.

The investigation stated a CNA was interviewed and stated "I was walking with {Resident's name}...{Resident's name} must have got tired and wanted to sit down. {Another resident} was sitting in her wheelchair next to the table. As {Resident's name} was sitting down she grabbed the handgrips on {the other Resident's} wheelchair. I stated to {Resident's name} to grab my hand not the wheelchair. When {Resident's name} was seated (5 seconds) she slapped {the other resident} on the right hand. {The other resident} then in turn slapped {Resident's name} on the right cheek. {Resident's} cheek had some redness initially, but it was gone by the end of our shift. I stepped between the two to separate them."

The investigation stated the Registered Nurse (RN) was interviewed and reported a resident was sitting at the table in the dining room and hit another resident on the right hand. The resident who was hit on the hand then slapped the other resident on her right cheek. The RN stated redness was noted to the resident's right cheek but no swelling and no signs or symptoms of pain were noted. The RN stated the residents were separated.

The investigation stated both residents were interviewed and did not remember the incident.

The Conclusion section of the investigation stated "Resident to Resident abuse unsubstantiated. Redness to cheek gone the following day." When asked, the Administrator stated on 2/27/20 at 10:27 AM, physical abuse was substantiated and the word "unsubstantiated" in the investigation was "a typo."

4. An investigation was submitted to the State Agency on 2/18/20, which documented a resident was physically abused by another resident on 2/18/20. The investigation documented that a CNA was walking with a resident when the resident attempted to throw her V8 can. The resident continued walking and was close to another resident who was sitting in the dining room. The resident who was seated reached out and grabbed the resident left wrist and squeezed it "with a menacing look." The CNA turned after catching the V8 can and saw the interaction between the residents. The CNA then placed herself between the residents.

The investigation stated the Licensed Practical Nurse (LPN) was interviewed and reported the CNA was walking with a resident for 1:1 care and the resident attempted to throw her V8 can. The resident continued walking, close to another resident. The resident who was seated reached out and grabbed the resident's left wrist and squeezed. The CNA turned after catching the V8 can and saw the interaction between the residents, and then placed herself between them. The LPN stated no injuries were noted.
The investigation stated both residents were interviewed. The resident who threw the V8 can did not respond to questions and the other resident stated that it could not have been her, because "she was not here until today."

The Conclusion section of the investigation stated, "Resident to Resident abuse unsubstantiated."

When asked, the Administrator stated on 2/27/20 at 10:27 AM, physical abuse was substantiated and the word "unsubstantiated" in the investigation was "a typo." The Administrator further stated the facility had "zero tolerance" for abuse and the abuse policy was to be implemented and followed by all staff.

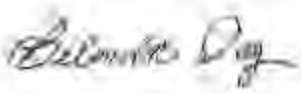
It was determined the facility failed to ensure residents were free from abuse. Therefore the allegation was substantiated and deficient practice was identified and cited at F600.

Conclusion: Substantiated. Federal deficiencies related to the allegation are cited.

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

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

Sincerely,



BELINDA DAY, RN, Supervisor
Long Term Care Program

BD/ac

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HEALTH & WELFARE

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April 17, 2020

Randal Barnes, Administrator
Valley Vista Care Center of St. Maries
820 Elm Street
St Maries, ID 83861-2119

Provider #: 135075

Dear Mr. Barnes:

On **February 25, 2020** through **February 27, 2020**, 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 #ID00008390

ALLEGATION #1:

The facility is not providing activities of daily living and care services in accordance with each resident's plan of care and choices.

FINDINGS #1:

During the survey, observations and interviews were conducted, and resident records were reviewed.

During the observations, residents were observed in various locations including common areas, the dining room, hallways, and in their rooms. Each of the residents were observed to be clean and well-groomed. The facility was without foul odors and call light response times were noted to be from 1 to 5 minutes.

One resident was interviewed and was asked about her experiences in the facility. The resident stated she was provided with care and services in accordance with her plan and based on her choices. The resident stated she was pleased with her care and services in the facility and had no concerns.

During the observations, 4 Certified Nurse Assistants (CNAs) were asked about providing activities of daily living care to residents. The CNAs discussed how to provide appropriate care to residents in order to meet their individual needs.

The CNAs were also asked behavioral health care services. The CNAs discussed how to identify residents with behavior related to past trauma and how to care for those specific residents. When asked about daily care, such as toileting and bathing, for residents who resisted care and displayed aggressive behavior, the CNAs stated they modified their approach, tried redirection, and offered alternatives.

Six resident records documented the residents were receiving appropriate care and services related to toileting, bathing, grooming and personal hygiene, and the residents' progress notes documented each resident's choices were respected.

Two of the 6 resident records documented the residents demonstrated aggressive and resistive behavior during toileting and bathing, and their care plans included appropriate interventions to address the behavior as well as ongoing monitoring and documentation related to their care. The residents' records also included documentation related to offering the residents alternatives to keep themselves clean.

Two of the 6 resident records also documented the residents periodically refused to take their medication and their care plans included appropriate interventions to address the refusal behavior. Additionally, both residents had behavior modification plans in place as well as ongoing monitoring and documentation of intervention results. The residents' records included documentation related to the residents' resistance to care and staff interventions.

It could not be determined that the facility was not providing activities of daily living and behavioral health care services in accordance with each resident's plan of care and choices.

Based on the investigative findings, the allegation could not be substantiated and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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

Sincerely,

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj