



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
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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](mailto:fsb@dhw.idaho.gov)

October 9, 2019

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

Provider #: 135069

Dear Mr. Royeca:

On **September 24, 2019**, a survey was conducted at Bell Mountain Village & Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 21, 2019**. Failure to submit an acceptable PoC by **October 21, 2019**, may result in the imposition of penalties by **November 10, 2019**.

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **October 29, 2019 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **December 24, 2019**. A change in the seriousness of the deficiencies on **November 8, 2019**, may

result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 24, 2019** includes the following:

Denial of payment for new admissions effective **December 24, 2019**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 24, 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 Chief, 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 **December 24, 2019** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

Darwin Royeca, Administrator  
October 9, 2019  
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<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)

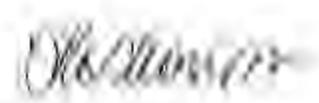
2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **October 21, 2019**. If your request for informal dispute resolution is received after **October 21, 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 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/dr

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

PRINTED: 10/25/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/24/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>BELL MOUNTAIN VILLAGE &amp; CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>620 NORTH SIXTH STREET</b> <b>BELLEVUE, ID 83313</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The following deficiencies were cited during the complaint investigation survey conducted 9/23/19 to 9/24/19.  The survey was conducted by:  Monica Meister, QIDP, Team Coordinator Karen George, RN  Survey Abbreviations:  DNS = Director of Nursing Services EHR = Electronic Health Record MDS = Minimum Data Set QAPI = Quality Assurance Performance Improvement	F 000			
F 623 SS=F	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)  §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.  §483.15(c)(4) Timing of the notice.	F 623		10/28/19	

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

TITLE

(X6) DATE

Electronically Signed

10/17/2019

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

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F 623	<p>Continued From page 1</p> <p>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State</p>	F 623			

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F 623	<p>Continued From page 2</p> <p>Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it</p>	F 623	F623 Notice Requirements Before		

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F 623	<p>Continued From page 3</p> <p>was determined the facility failed to ensure written notification of transfers were provided to residents and their representatives when they were transferred to the hospital. This was true for 2 of 2 residents (#3 and #4) reviewed for transfers. This failure created the potential for harm for all residents if they were unable to exercise their rights related to transfers due to lack of written notification. Findings include:</p> <p>a. Resident #3 was admitted to the facility on 11/13/17 and readmitted to the facility on 4/4/19, with multiple diagnoses including bipolar disorder (a mental health condition that causes extreme mood swings).</p> <p>Resident #3's MDS, dated 4/3/19, documented Resident #3 was discharged to the hospital with an anticipated return to the facility. Resident #3's record did not include documentation he received written notification of the transfer from the facility.</p> <p>On 9/24/19 at 8:39 AM, the DNS said Resident #3's record did not include documentation the facility provided him a notification of transfer when he was discharged to the hospital on 4/3/19.</p> <p>b. Resident #4 was admitted to the facility on 11/18/17, and readmitted on 6/14/19, with multiple diagnoses including severe bipolar disorder.</p> <p>Resident #4's MDS, dated 5/31/19, documented she was discharged with an anticipated return to the facility. Resident #4's record did not include documentation she received written notification of the transfer from the facility.</p>	F 623	<p>Transfer/Discharge</p> <p>This facility will ensure written notification of transfers are provided to residents and their representatives when they are transferred to the hospital.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident # 3 was readmitted to the facility 4/4/2019 and has not had any discharges or transfer after readmission of 4/4/2019.</p> <p>Resident # 4 was readmitted to the facility 6/14/2019 and has not had any discharges or transfer after readmission of 6/14/2019.</p> <p>How you will identify other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken.</p> <p>All residents that had been transferred or discharged have the potential to be affected by the deficient practice.</p> <p>Department Head Staff and Licensed Nurses have been in serviced on Federal Citation, Deficient Practice and the importance of giving resident and /or responsible party written notification before transfer or discharged.</p> <p>What measures will be put in place and what systemic changes will be made to</p>		

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F 623	Continued From page 4  On 9/24/19 at 8:39 AM, the DNS said Resident #4's record did not include documentation the facility provided her with a notification of transfer when she was discharged to the hospital on 5/31/19.  On 9/24/19 at 8:47 AM, the Resident Services Director said the facility did not provide a notification of transfer to residents when they were transferred to the hospital. She said she did not realize providing notification of transfer was a requirement.  On 9/24/19 at 9:44 AM, the Health Information Director said she did not know the facility needed to provide written notification of transfer to residents when they were sent to the hospital. She said this was not a facility practice and was unsure if it was necessary.  On 9/24/19 at 10:20 AM, the Administrator said the facility did not provide transfer notices to residents when they were transferred.	F 623	ensure that the deficient practice does not recur.  Department Head Staff and Licensed Nurses have been in serviced on Federal Citation, Deficient Practice and the importance of giving the resident and or responsible party written notification before transfer or discharge .  A transfer or discharge packet consisting of written notification of transfer or discharge has been prepared and placed in each resident chart for easy access for discharging Licensed Nurses to send with resident when leaving in an emergency situation.  Resident Service Director and or discharging Nurse will notify responsible party by phone of the transfer or discharge and a copy of the written notice will be mailed out for signature via certified mail. And a copy will be sent to the Ombudsman.  Audit or Tracking sheet will be filled out by Resident Services Coordinator to ensure compliance.  Indicate how the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained.  Random audits will be done by the Administrator or Designee. Audits will be completed weekly x 4, bimonthly x 2, then		

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F 623	Continued From page 5	F 623			
F 625 SS=F	<p>Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)</p> <p>§483.15(d) Notice of bed-hold policy and return-</p> <p>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-</p> <p>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on policy review, record review and staff</p>	F 625	<p>monthly x 3. The results of all audits will be presented to the QAPI committee for further monitoring and modification based on the findings.</p> <p>F625 Notice of Bed Hold Policy/Upon</p>	10/28/19	

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F 625	<p>Continued From page 6</p> <p>interview, it was determined the facility failed to ensure bed-hold notices were provided to residents and their representatives when they were transferred to the hospital. This was true for 2 of 2 residents (#3 and #4) reviewed for transfers. This failure created the potential for harm for all residents being transferred if they were not informed of their right to return to their former room at the facility within a specified time. Findings include:</p> <p>The facility's Bed-Holds and Returns policy, revised December 2016, stated prior to transfers and therapeutic leaves, residents or resident representatives were informed in writing of the bed-hold and return policy. The policy further documented:</p> <p>* Prior to a transfer, written information was given to the residents and the resident representatives that explains in detail:</p> <ul style="list-style-type: none"> <li>- The duration of the bed-hold;</li> <li>- The reserve bed payment policy as indicated by the state plan; and</li> <li>- The details of the transfer (per the Notice of Transfer).</li> </ul> <p>The facility did not follow this policy.</p> <p>a. Resident #3 was admitted to the facility on 11/13/17, and readmitted to the facility on 4/4/19, with multiple diagnoses including bipolar disorder (a mental health condition that causes extreme mood swings).</p> <p>Resident #3's MDS assessment, dated 4/3/19, documented Resident #3 was discharged with an anticipated return to the facility. Resident #3's</p>	F 625	<p>Transfer</p> <p>This facility will ensure bed-hold notices were provided to residents and their representatives when they are transferred to the hospital.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident # 3 was readmitted to the facility 4/4/2019 and has not had any discharges or transfer after readmission of 4/4/2019.</p> <p>Resident # 4 was readmitted to the facility 6/14/2019 and has not had any discharges or transfer after readmission of 6/14/2019.</p> <p>How you will identify other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken.</p> <p>All residents that had been transferred or discharged have the potential to be affected by the deficient practice.</p> <p>Department Head Staff and Licensed Nurses have been in serviced on Federal Citation, Deficient Practice and the importance of giving resident and /or responsible party written notification of bed hold policy before transfer or upon discharge to the hospital.</p>		

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F 625	<p>Continued From page 7</p> <p>MDS assessment, dated 4/4/19, documented the resident was readmitted to the facility.</p> <p>Resident #3's record did not include documentation the facility provided him notification of the bed-hold policy when he was discharged to the hospital on 4/3/19.</p> <p>On 9/24/19 at 8:39 AM, the DNS said Resident #3's record did not include documentation the facility provided Resident #3 with notification of the bed-hold policy when he was discharged to the hospital on 4/3/19.</p> <p>b. Resident #4 was admitted to the facility on 11/18/17, and readmitted to the facility on 6/14/19, with multiple diagnoses including severe bipolar disorder.</p> <p>Resident #4's MDS, dated 5/31/19, documented she was discharged with an anticipated return to the facility. Resident #4's MDS, dated 6/14/19, documented she was readmitted to the facility.</p> <p>Resident #4's record did not include documentation the facility provided Resident #4 notification of the bed-hold policy when she was discharged to the hospital on 5/31/19.</p> <p>On 9/24/19 at 8:39 AM, the DNS said the facility only sent the items listed on the Discharge/Transfer form when a resident was sent to the hospital. She was unsure if a bed-hold notification was part of the information provided to residents when they were transferred.</p> <p>On 9/24/19 at 9:00 AM, RN #1 said documents listed on the Discharge/Transfer sheet were sent</p>	F 625	<p>What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Department Head Staff and Licensed Nurses have been in serviced on Federal Citation, Deficient Practice and the importance of giving the resident and or responsible party written notification of bed hold before transfer or upon discharge to the hospital.</p> <p>A transfer or discharge packet consisting of written notification of bed hold policy has been prepared and placed in each resident chart for easy access for discharging Licensed Nurses to send with resident when leaving in an emergency situation.</p> <p>Resident Service Director and or discharging Nurse will notify responsible party by phone of the transfer or discharge and a copy of the written notice will be mailed out for signature via certified mail. And a copy will be sent to the Ombudsman.</p> <p>Audit or Tracking sheet will be filled out by Resident Services Coordinator to ensure compliance.</p> <p>Indicate how the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/24/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>BELL MOUNTAIN VILLAGE &amp; CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>620 NORTH SIXTH STREET</b> <b>BELLEVUE, ID 83313</b>		
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F 625	Continued From page 8 with residents going to the hospital. She said the facility never provided a bed-hold notice or a written notice to the resident.  Review of the Discharge/Transfer Form, undated, did not include instructions regarding bed-hold notification when a resident was transferred or discharged.  On 9/23/19 at 11:20 AM, the Health Information Director said bed-hold notifications were not provided to any transferred or discharged residents.  On 9/24/19 at 10:20 AM, the Administrator said the facility was not diligently providing bed-hold notifications to residents who were being transferred.  The facility failed to ensure bed hold notices were provided to residents being transferred to the hospital.	F 625	Random audits will be done by the Administrator or Designee. Audits will be completed weekly x 4, bimonthly x 2, then monthly x 3. The results of all audits will be presented to the QAPI committee for further monitoring and modification based on the findings.		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmp CFR(s): 483.75(a)(2)(h)(i)  §483.75(a) Quality assurance and performance improvement (QAPI) program.  §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;  §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.	F 865		10/28/19	

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F 865	<p>Continued From page 9</p> <p>§483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on policy review, record review, review of the facility's QAPI program, and staff interview, it was determined the facility failed to ensure a plan was developed for conducting QAPI activities and opportunities for improvement. This failure impacted 2 of 2 residents (#3 and #4) reviewed for transfers and had the potential to impact all residents residing in the facility. This created the potential for harm if residents received substandard quality of care from lack of identification and correction to quality deficiencies. Findings include:</p> <p>1. Resident #3's MDS assessment, dated 4/3/19, documented Resident #3 was discharged on that date with an anticipated return to the facility. Resident #4's MDS, dated 5/31/19, documented she was discharged on that date with an anticipated return to the facility. The records of Resident #3 and Resident #4 did not include documentation they were provided with written notices of transfer nor were they provided with the facility's bed-hold policy.</p> <p>On 9/23/19 at 11:20 AM, the Health Information Director said bed-hold notifications were not provided to any transferred or discharged residents. On 9/24/19 at 10:20 AM, the Administrator said the facility did not provide transfer notices to residents when they were transferred.</p>	F 865	<p>F865 QAPI Program/Plan, Disclosure/Good Faith Attempt.</p> <p>This facility will ensure a plan are develop for conducting QAPI activities and opportunities for improvement.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>All residents have the potential to be affected by the deficient practice. See POC F623 and F625.</p> <p>How you will identify other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken.</p> <p>All residents have the potential to be affected by the deficient practice. See POC F623 and F625.</p> <p>What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>The facility's QAPI Committee will review,</p>		

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F 865	<p>Continued From page 10</p> <p>The facility's Quality Assurance/Performance Improvement Policy and Procedure policy, revised 10/2013, did not include information related to written notification of transfers or the facility's bed-hold policy.</p> <p>On 9/24/19 at 11:00 AM, the Health Information Director stated she was the chairperson for QAPI committee. She stated she did not know there were concerns related to written transfers and the bed-hold policy until it was identified by the survey team. The Health Information Director stated when issues were identified throughout the month, they were added to the QAPI plan.</p> <p>The Quality Assurance/Performance Improvement Policy and Procedure, dated 9/2013, did not include processes to guide the facility's efforts in assuring care and services were maintained at acceptable levels of performance and continually improved. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> <li>- The policy stated the Performance Improvement committee was to "Provide a centralized coordinated approach to Performance Improvement [PI] activities to meet the needs of the facility."</li> </ul> <p>There was no additional information related to how the committee was to accomplish the task and no timeframes were present in the policy.</p> <ul style="list-style-type: none"> <li>- The policy stated the Performance Improvement committee was to "Provide a system for reviewing, reporting, and documenting</li> </ul>	F 865	<p>revise and update the facility's Quality Assurance/Performance Improvement Policy and Procedure on the next facility QAPI meeting to include information related to written notification of transfer and bed hold policy.</p> <p>The facility's QAPI Committee will review, revise and update the facility's Quality Assurance/ Performance Improvement Policy and Procedure for Performance Improvement activities , evaluation of all activities, plans of corrections, changes in policies and/or procedures, outcomes on the next facility QAPI Committee meeting to include objectives, systematic approach to guide the committee on accomplishing task and time frame for expected outcome or goal.</p> <p>Facility will have QAPI committee meeting at least Quarterly.</p> <p>Indicate how the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained .</p> <p>The Governing Body and/or designee will audit on a quarterly basis to ensure compliance. The Governing Body and/or designee is responsible for compliance.</p>		

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F 865	<p>Continued From page 11 all PI activities, including Infection Control, Safety and all facility departments."</p> <p>There was no additional information related to how the committee was to accomplish the task and no timeframes were present in the policy.</p> <p>- The policy stated the Performance Improvement committee was to "Evaluate all PI data collection, monitoring tools and activities for appropriateness, standards and effectiveness."</p> <p>There was no additional information related to how the committee was to accomplish the task and no timeframes were present in the policy.</p> <p>- The policy stated the Performance Improvement committee was to "Assist all facility departments and individuals in the PI process."</p> <p>There was no additional information related to how the committee was to accomplish the task and no timeframes were present in the policy.</p> <p>- The policy stated the Performance Improvement committee was to "Evaluate all activities/plans of correction, changes in policies and/or procedures, outcomes, etc."</p> <p>There was no additional information related to how the committee was to accomplish the task and no timeframes were present in the policy.</p> <p>On 9/24/19 at 11:00 AM, the Health Information Director stated she was given the QAPI task 8 months ago and "it's a work in progress."</p> <p>The facility failed to ensure a plan was developed</p>	F 865			

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F 865	Continued From page 12 for conducting QAPI activities and opportunities for improvement.	F 865			



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
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October 11, 2019

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

Provider #: 135069

Dear Mr. Royeca:

On **September 24, 2019**, an unannounced on-site complaint survey was conducted at Bell Mountain Village & Care Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008076**

**ALLEGATION #1:**

The facility sent residents to the emergency room for evaluation and placement related to behavioral concerns without the resident's consent or need for further evaluation.

**FINDINGS #1:**

An unannounced on-site complaint survey was conducted from 9/23/19 to 9/24/19. During that time, resident records were reviewed, facility policy's were reviewed, and staff interviews were conducted with the following results:

Three residents who were transferred or discharged were selected for review. One resident discharged from the facility and did not return.

Two of the records documented they were transferred to a hospital and were subsequently re-admitted to the facility. Their records did not contain evidence the residents were provided with a written notice of transfer or the written notice of the facility's bed-hold policy.

In an interview on 9/23/19 at 11:20 AM, the Health Information Director said the facility previously had

Darwin Royeca, Administrator  
October 11, 2019  
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sent a hard copy of the 30-day bed hold notice with residents when they were sent to the emergency department. She said when the facility switched to the use of Point Click Care (an electronic record system), this process "just got dropped." The Health Information Director said written notification of the facility's bed-hold policy was not being provided to any transferred or discharged resident.

In an interview on 9/24/19 at 9:44 AM, the Health Information Director said she did not know the facility needed to provide a notification of transfer to the resident in writing, when a resident was transferred.

The facility's Quality Assurance/Performance Improvement (QAPI) Policy and Procedure, revised October 2013, did not contain any information related to written notification of transfers or the facility's bed-hold policy.

When asked, the Health Information Director stated during an interview on 09/24/19 at 11:00 AM, she was the chairperson for QAPI. She stated she did not know there were concerns related to written transfers and the bed-hold policy until it was identified by the survey team.

Based on the investigative findings, the allegation could not be substantiated. However, the facility failed to provide written notifications of transfer and bed hold notices to residents who were transferred to the hospital and failed to ensure a plan was developed that described the process for conducting QAPI activities as well as opportunities for improvement. Therefore, deficient practice was identified and cited at F623, F625, and F865.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, 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

Darwin Royeca, Administrator  
October 11, 2019  
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IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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LICENSING & CERTIFICATION  
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FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

October 15, 2019

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

Provider #: 135069

Dear Mr. Royeca:

On **September 24, 2019**, an unannounced on-site complaint survey was conducted at Bell Mountain Village & Care Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008213**

**ALLEGATION #1:**

The facility is not thoroughly investigating injuries of unknown origin and appropriate corrective action to prevent reoccurrence is not taken.

**FINDINGS #1:**

An unannounced on-site complaint survey was conducted from 9/23/19 to 9/24/19. During that time, observations, resident record review, and staff interviews were conducted with the following results:

Observations were conducted in the facility on 9/23/19 and 9/24/19. No concerns related to injuries of unknown origin were identified. During observations, certified nursing assistants stated all injuries of unknown origin were reported to nursing staff and investigated.

Three residents who sustained injuries were selected for record review. One resident's record documented 3 injuries of unknown origin were discovered and were investigated, as follows:

On 5/2/19, the resident was found with a laceration to her leg. The facility's investigation documented they were unable to determine the cause of the injury and the plan of correction was to pad any and all surfaces that may cause a laceration.

On 7/17/19, the resident was found with swelling and bruising to the resident's left hand. The facility's investigation documented interviews with staff revealed the resident was combative the prior day during cares. In response to the injury, the facility's plan of correction was all staff were counseled to be observant and to notify nursing of any bruises, skin tears, swelling, etc.

On 7/24/19, the resident was found with a bruise to the right hand and an abrasion to the right shoulder. In response to the investigation, the facility placed padding to the wall behind the resident's bed and placed a pillowcase cover to the resident's bedrail to prevent the resident's hand being injured. The investigation also documented all staff were in-serviced on using appropriate technique and safety when wheeling residents through doorways. The investigation stated the facility was going to continue providing two staff for cares of the resident to ensure safety.

The resident's room was observed on 9/23/19 at 3:40 PM, and she was present laying in bed. The resident's bed was in the low position and there were two mats on the wall next to her bed on the resident's right side. The resident's wheelchair was also in the room and it had a chair cushion for pressure relief, padding on the lower bars of the wheelchair, and screws and bolts were covered with tape.

The resident's record included a care conference note, dated 9/18/19, which documented she had increased behaviors directed toward other residents and the daughter did not want her to take medications due to side effects. The note documented the resident was also "aggressive" and "combative" to staff when cares were provided. The care conference note documented an air overlay mattress was to be placed on her bed and she was to have Derma-Savers to both her lower extremities at all times. Derma-Savers are cloth to protect the skin from pressure, friction and minor trauma.

Based on the investigative findings, the allegation could not be substantiated.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Darwin Royeca, Administrator  
October 15, 2019  
Page 3 of 3

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

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

Sincerely,

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

Laura Thompson, RN, Supervisor  
Long Term Care Program

LT/lj