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IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER - Governor
RICHARD M. ARMSTRONG - Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Eder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

January 27, 2015

Brian J. Davidson, Administrator
Good Samaritan Society - Boise Village
3115 Sycamore Drive
Boise, ID 83703-4129

Provider #: 135085

Dear Mr. Davidson:

On **January 15, 2015**, a Complaint Investigation survey was conducted at Good Samaritan Society - Boise Village by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form 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" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag 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 both the Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 9, 2015**. Failure to submit an acceptable PoC by **February 9, 2015**, may result in the imposition of civil monetary penalties by **March 2, 2015**.

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.
- 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 both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **February 19, 2015 (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 **February 19, 2015**. A change in the seriousness of the deficiencies on **February 19, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **February 19, 2015** includes the following:

Brian J. Davidson, Administrator
January 27, 2015
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Denial of payment for new admissions effective **April 15, 2015**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 15, 2015**, 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, they will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., 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 **January 15, 2015** 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 noncompliance 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)

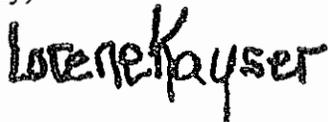
Brian J. Davidson, Administrator
January 27, 2015
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2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **February 9, 2015**. If your request for informal dispute resolution is received after **February 9, 2015**, 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 Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser". The signature is written in a cursive, slightly slanted style.

LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor
Long Term Care

LKK/dmj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/15/2015
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - BOISE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 SYCAMORE DRIVE BOISE, ID 83703
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS The following deficiency was cited during a complaint survey of your facility. The surveyors conducting the survey were: Susan Gollobit, RN, Team Coordinator Ashley Henscheid The survey team entered and exited the facility on January 15, 2015.	F 000	<p style="text-align: right;">RECEIVED FEB - 4 2015</p> <p>General Disclaimer</p> <p>Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations manual.</p> <p>F315 – No Catheter, Prevent UTI, Restore Bladder</p> <p>Resident Specific</p> <p>The Foley catheter was changed for resident #4 on 1/15/15 and the TAR was updated to reflect the new monthly cycle per physician's order. Foley catheter care is being</p>	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure 1 of 3 (#4) residents reviewed for catheters were provided catheter care as ordered by the physician. Failure to ensure an indwelling catheter was changed as ordered by the physician had the potential to result in a urinary tract infection (UTI) or complications related to a UTI. Findings included: Resident #4 was admitted to the facility on 8/21/14 with diagnoses that included senile	F 315		2/13/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 2/4/15
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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: 135085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/15/2015
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - BOISE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 3115 SYCAMORE DRIVE BOISE, ID 83703		
(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 315	<p>Continued From page 1 dementia and a UTI.</p> <p>A Clinical Referral form dated 10/24/14 documented the resident was seen by the physician and diagnosed with urinary retention. A Foley catheter was started and an order for the catheter to be changed monthly was written.</p> <p>The resident's recapitulation physician order documented: *Foley catheter 16 French (size/type) with 10 cubic centimeter (cc) balloon. Order date 10/24/14. *Change Foley catheter monthly 16 French with 10 cc balloon.... for retention of urine. Start date 11/24/14. *Foley catheter care every shift. Start date 10/24/14.</p> <p>The resident's Treatment Administration Records (TARs) for November, December 2014 and January 1-15, 2015, documented a space to sign when the catheter was changed. The records did not document the catheter had been changed.</p> <p>A 12/3/14 license nurse (LN) Progress Note documented the resident's catheter was changed using sterile technique related to the physician order and the resident's urine was clear yellow.</p> <p>The January 1-15, 2015 TAR documented the resident was supposed to receive Foley catheter care every shift. The TAR did not document the catheter care was completed on day shift on 1/11 and 1/13 or night shift on 1/5 and 1/13/15.</p> <p>On 1/15/15 at 2:45 PM, the Unit Manager (UM) and Director of Nurses (DON) were asked for the documentation of the resident's catheter being</p>	F 315	<p>completed each shift and documented.</p> <p><u>Other Residents</u></p> <p>All residents with Foley catheters have the potential to be affected if catheters are not changed and catheter care is not provided according to the physician's order as noted in the TAR. Audits of all residents with Foley catheters will be completed by 2/13/15 to ensure catheters are being changed and catheter care is being provided according to the physician's order and is documented in the TAR.</p> <p><u>Facility System</u></p> <p>In-servicing will be completed on 2/9/15 and 2/11/15 for all licensed nurses to ensure Foley catheters are being changed and catheter care is being provided per physician's order and documented in the TAR.</p> <p><u>Monitor</u></p> <p>Starting on 2/13/15, the RN care managers will audit weekly x 4, bi-weekly x 4, and then monthly x 3 to</p>		

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

PRINTED: 01/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/15/2015
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - BOISE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 3115 SYCAMORE DRIVE BOISE, ID 83703		
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F 315	<p>Continued From page 2</p> <p>changed in November, December and January. A 4:00 PM, the UM and DON provided the LN Progress Note as documented above that the catheter had been changed on 12/3/14. The UM stated the resident's catheter was started on 10/24 in the physician's office. The need for it to be changed was "missed" in November and was changed on 12/3. The UM and DON were asked if the catheter had been changed in January. The DON stated, "No, it's due to be changed on the 24th." The DON was asked if the catheter should have been changed on 1/3/15 since it had last been changed on 1/3/15. The DON told the UM the catheter needed to be changed "today."</p> <p>On 1/15/15 at 4:15 PM, the Administrator and the DON were notified of the findings. No additional information was provided.</p>	F 315	<p>ensure Foley catheters are changed and catheter care is being provided per physician orders and documented in the TAR. Audit results will be reported to the monthly QAPI meetings for further monitoring and plan modification.</p> <p><u>Date of Compliance</u></p> <p>February 13, 2015</p>		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2015
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NAME OF PROVIDER OR SUPPLIER
GOOD SAMARITAN SOCIETY - BOISE VILLAGI

STREET ADDRESS, CITY, STATE, ZIP CODE
**3115 SYCAMORE DRIVE
BOISE, ID 83703**

(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) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS The following deficiency was cited during a complaint survey of your facility. The surveyors conducting the survey were: Susan Gollobit, RN, Team Coordinator Ashley Henscheid The survey team entered and exited the facility on January 15, 2015.	C 000	<p><u>General Disclaimer</u></p> <p>Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations manual.</p> <p>C 650 – Resident Care Practices</p> <p>Please refer to Plan of Correction for F315.</p>	
C 650	02.150,01,a,vii Resident Care Practices vii. Resident care practices, i.e., catheter care, dressings, decubitus care, isolation procedures. This Rule is not met as evidenced by: Refer to F315 related to management of Foley catheters.	C 650		2/13/15

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FEB - 5 2015
FACILITY STANDARDS

Bureau of Facility Standards

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

TITLE: **Administrator**

(X6) DATE: **2/4/15**



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
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January 27, 2015

Brian J. Davidson, Administrator
Good Samaritan Society - Boise Village
3115 Sycamore Drive
Boise, ID 83703-4129

Provider #: 135085

Dear Mr. Davidson:

On **January 15, 2015**, an unannounced, on-site Complaint Investigation survey was conducted at Good Samaritan Society - Boise Village. Susan Gollobit, R.N. and Ashley Henscheid, Q.I.D.P. conducted the complaint investigation.

During the investigation the Director of Nursing (DoN), three License Nurse's (LN) and two Unit Managers (UM) were interviewed. Narcotics that had been discontinued were observed in two medication carts and in the DoN's locked cabinet. Discontinued medication cards were observed as well.

The complaint allegations, findings and conclusions are as follows:

Complaint #6712

ALLEGATION:

The complainant stated the following:

- a) Discontinued narcotic medications are taken to the DoN, who keeps them in a drawer and destroys them at a later time with other LN's.

- b) Staff is not allowed to write either the discontinued date or the pill count on the narcotic cards.
- c) The discontinued medications must be kept in the medication cart until they are delivered to the DoN.

FINDINGS:

a) On January 15, 2015, two UMs were interviewed. They both stated the DoN had a locked cabinet in her office where discontinued narcotic medications were kept. They said they had been involved in the destruction of discontinued narcotic medications. They stated the medication cards and the narcotic count sheet are reconciled by the DoN and the UM prior to destroying the medications.

Based on interviews and observations, it was determined narcotics were secured in a locked medication cart or a locked cabinet in the DoN's office until they are destroyed.

b) Three LNs who were interviewed during the investigation identified that the process for discontinued narcotics was to pull the medication dispensing card and the narcotic count sheet. On the narcotic count sheet, the amount of medication that was left was circled by the LN. The sheet was then secured with a rubber band to the back of the card. The circled amount on the narcotic sheet is visible and the pills on the front side are visible so the medication can be counted. Two medication carts were observed. Both of the medication carts had discontinued narcotic medication cards and medications were observed to be secured as the LN had described. The count and discontinued date were documented on the narcotic sheet.

Staff stated they are allowed to write on the medication cards. The system in place provided for documentation to identify the amount of pills left in the card and on the narcotic sheet.

c) During the investigation, three LNs and two UMs were asked how the discontinued narcotics were delivered to the DoN. Two of the LNs stated they bring them to the DoN, and if she is not in the building, the narcotic cards are stored in the locked narcotic drawer on the medication cart until the DoN is available. The third LN stated she left the discontinued narcotics in the locked box on the medication cart and her UM picked them up and took them to the DoN. One UM stated that on her unit, the DoN came by and picked them up. The second UM stated she took them to the DoN when the DoN was available. All five staff verified the discontinued narcotics were kept in the double lock system on the cart as required, until the DoN was available to secure them for disposal.

Based on observations and interviews it was determined staff were able to take the discontinued medications to the DoN when they are discontinued, provided she is available.

Brian J. Davidson, Administrator
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Page 3 of 3

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser". The signature is written in a cursive, slightly slanted style.

LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor
Long Term Care

LKK/dmj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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January 27, 2015

Brian J. Davidson, Administrator
Good Samaritan Society - Boise Village
3115 Sycamore Drive
Boise, ID 83703-4129

Provider #: 135085

Dear Mr. Davidson:

On **January 15, 2015**, an unannounced, on-site Complaint Investigation survey was conducted at Good Samaritan Society - Boise Village. Susan Gollobit, R.N. and Ashley Henscheid, Q.I.D.P. conducted the complaint investigation.

The complaint allegations, findings and conclusions are as follows:

Complaint #6815

ALLEGATION #1:

The complainant stated an identified resident was not provided medical interventions for a lack of bowel movements, resulting in a bowel obstruction and surgery.

FINDINGS #1:

During the investigation, records reviews and interviews with facility's staff were completed with the following results:

Four residents were selected for review. The identified resident was discharged to the hospital. Hospital records documented the resident was admitted for a bowel obstruction and surgery was

required. However, the documentation indicated it was "secondary to a colon carcinoma" and "earlier intervention likely would not have made a significant change."

Progress notes dated March 1, 2014 - January 15, 2015, were reviewed. The progress notes included some documentation of bowel movements as well as when residents were placed on the "bowel list."

An interview was conducted with the Director of Nursing (DoN) on January 15, 2015, at 1:18 p.m. The DoN stated to be placed on the "bowel list" meant a resident had not had a bowel movement for three days. The DoN stated nursing staff monitored any resident on the "bowel list" for 72 hours as well as administered medications for constipation. On the third day with no bowel movement, a resident receives milk of magnesia, on the fourth day, they receive a suppository and on the fifth day, they receive an enema. The DoN stated enemas were rarely used in the facility. The DoN stated orders for constipation medications are obtained as needed. Therefore, communication with the physician occurs throughout the monitoring.

Interviews were conducted with five staff members, including three licensed nurses, a certified nurse aide and a unit manager. All were able to describe proper interventions for a lack of bowel movements.

Bowel tracking was reviewed from October 1, 2014 - January 15, 2015. When cross-referenced with the progress notes, documentation showed residents had routine bowel movements or were placed on the "bowel list," as described by the DoN.

Based on records reviewed and interviews with staff, it could not be determined that any resident did not receive interventions for a lack of bowel movements.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant said an identified resident with a catheter was not provided needed medical care and developed a urinary tract infection.

FINDINGS #2:

Records reviews and interviews with facility's staff were completed with the following results:

Three residents who utilized a catheter, which included the identified resident, were selected for

Brian J. Davidson, Administrator
January 27, 2015
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review. Physicians' orders were reviewed from October 1, 2014 - January 15, 2015. Each of the resident's record contained physician's orders for daily catheter care, in addition to monthly catheter changes.

Treatment administration records were reviewed. The records contained spaces for staff to sign their initials and to document both daily catheter care as well as monthly catheter changes. The record of one resident did not document that daily catheter care was completed on the day shift of January 11 and 13, 2015, or on the night shift of January 5 and 13, 2015. Additionally, the resident's record did not include documentation of monthly catheter changes.

Progress notes dated October 1, 2014 - January 15, 2015, were reviewed. The progress notes included additional documentation of routine and as needed catheter changes for two of the residents. The progress notes included documentation of one catheter change on December 3, 2014, for the third resident. However, the resident's catheter, initiated October 24, 2014, was ordered to be changed November 24, 2014, December 24, 2014 and January 24, 2015.

An interview was conducted with the DoN on January 15, 2015, at 2:45 p.m. She stated the December 3, 2014, catheter change was a late change for the one scheduled on November 24, 2014. The DoN stated it was the only change completed between November 24, 2014 and January 15, 2015, because routine changes had been missed.

The allegation was substantiated, as a resident did not receive monthly catheter changes as ordered by the physician. The facility was cited at F315.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #3:

The complainant stated the facility does not communicate with residents' family members regarding changes in health status.

FINDINGS #3:

Records reviews and interviews with facility's staff were completed with the following results:

Interviews were conducted with two facility employees. One stated she had communicated with family members as needed, when they were on-site. The second employee, the point-of-contact for facility's complaints, stated she was not aware of any communication concerns from family members. She stated employees communicated with family members regularly and made entries

Brian J. Davidson, Administrator
January 27, 2015
Page 4 of 4

in resident's progress notes.

Four residents were selected for review. Progress notes dated March 1, 2014 - January 15, 2015, were reviewed for each of the residents with no concerns noted. The progress notes include documentation of communication with family members regarding all changes in each resident's status.

Based on records reviewed and interviews with staff, it could not be determined that communication between the facility and family members was lacking.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626, Option #2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser". The signature is written in a cursive, slightly slanted style.

LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor
Long Term Care

LKK/dmj