



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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April 29, 2016

Jamie Berg, Administrator
Good Samaritan Society-- Moscow Village
640 North Eisenhower Street
Moscow, ID 83843-9588

Provider #: 135067

Dear Ms. Berg:

On **April 15, 2016**, a survey was conducted at Good Samaritan Society-- Moscow 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 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.

Jamie Berg, Administrator
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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 **May 9, 2016**. Failure to submit an acceptable PoC by **May 9, 2016**, may result in the imposition of penalties by **June 3, 2016**.

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 **July 14, 2016 (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 **July 14, 2016**. A change in the seriousness of the deficiencies on **May 30, 2016**, may result in a change in the remedy.

Jamie Berg, Administrator
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The remedy, which will be recommended if substantial compliance has not been achieved by **July 14, 2016** includes the following:

Denial of payment for new admissions effective **July 14, 2016**. [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 **October 12, 2016**, 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 David Scott, R.N. or Nina Sanderson, L.S.W., 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 **July 14, 2016** 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>

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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 **May 9, 2016**. If your request for informal dispute resolution is received after **May 9, 2016**, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in black ink that reads "Nina Sanderson". The signature is written in a cursive style and is positioned above a horizontal line.

Nina, Sanderson, LSW, Supervisor
Long Term Care

NS/lj
Enclosures

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

PRINTED: 06/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/15/2016
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 640 NORTH EISENHOWER STREET MOSCOW, ID 83843		
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the on-site federal recertification and complaint survey conducted April 11, 2016 to April 15, 2016.</p> <p>The surveyors conducting the survey were: Linda Kelly, RN, Team Leader David Scott, RN Jenny Walker, RN</p> <p>Definitions:</p> <p>AIT = Administrator in Training BIMS = Brief Interview for Mental Status CNA = Certified Nursing Assistant COTA = Certified Occupational Therapy Assistant DNS = Director of Nursing Services FDA = Food and Drug Administration LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set MSSA=Methicillin Sensative Staphylococcus aureus RN = Registered Nurse RNCM = Registered Nurse Case Manager OT = Occupational Therapy PICC = Peripherally Inserted central Catheter PPS = Prospective Payment System PRN = As Needed PT = Physical Therapy s/s = Signs and symptoms UTI = Urinary Tract Infection Rehab = Rehabilitation ROC = Regional Operations Consultant R/T = Related to TAR = Treatment Administration Record w/c = Wheelchair</p>	F 000			
F 252	483.15(h)(1)	F 252		6/6/16	

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

TITLE

(X6) DATE

Electronically Signed

05/05/2016

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 252 SS=D	<p>Continued From page 1</p> <p>SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the Rehab Department sink and microwave were maintained in clean condition. This failure created the potential for a negative psychosocial effect for 2 sample residents (#s 2 and 3) who received OT services and other residents who received OT services. Findings included:</p> <p>On 4/12/16 at 9:20 am, a dried film of debris was observed across the bottom surface and all sides of the sink in the Rehab Department. Unwashed dishes, including a yellow smiley face cup, a small bowl, a fork, and a plastic whipped cream container and lid, were in the sink. A 5 inch by 2 inch area of dried, raised yellowish substance was observed on the glass plate in the microwave.</p> <p>On 4/13/16 at 11:25 am, the dried film of debris was again observed on all sides of the Rehab Department sink and a plastic whipped cream container and lid were in the sink. In addition, the yellowish substance was again observed on the glass plate in the microwave. COTA #5 was present at the time. The COTA said some residents who received OT services did use the</p>	F 252	<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>F252:</p> <ol style="list-style-type: none"> 1. The Rehab Department sink and microwave were cleaned. 2. All residents receiving OT services have the potential to be affected. 3. The QAPI process identified the root cause of the deficiency as the lack of a procedure and assignments for cleaning the Therapy kitchen. A kitchen cleaning procedure will be developed for Therapy. 		

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F 252	Continued From page 2 sink and microwave at times and occasionally resident training involved cleaning the sink and microwave. The COTA said the sink had been cleaned earlier in the week and that she did not know when the microwave was last cleaned.	F 252	All therapy and housekeeping staff will be educated on the cleaning procedure. 4. The Housekeeping Director or designee will audit the therapy kitchen daily x5, weekly x3, monthly x1 and quarterly x1. All audit findings will be reported to the QAPI Committee for further monitoring and modification. 5. Corrective action will be completed by June 6, 2016.		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff and resident interview,	F 279	Preparation and Execution of this	6/6/16	

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F 279	<p>Continued From page 3</p> <p>observation, and record review, it was determined the facility failed to ensure residents' clinical care plans were revised to provide accurate and complete direction to staff. This was true for 1 of 15 residents (#9) reviewed for care plans and had the potential to cause more than minimal harm when Resident #9's dialysis care plan failed to direct staff to carefully assess and monitor the resident's dialysis delivery sites. Failure to carefully monitor the resident's peripheral and central port sites could lead to complications, including infection. Findings include:</p> <p>Resident #9 was admitted to the facility on 2/28/16 with diagnoses that included chronic kidney disease. The resident was re-admitted on 3/22/16 with diagnoses that included chronic kidney disease and MSSA infection to the resident's chest where her dialysis central port was located.</p> <p>Resident #9's undated care plan documented: *Focus - "Hemodialysis Mon, Wed, Fri r/t renal failure." *Goal - "[Resident #9] will have no s/s of complications from dialysis..." *Interventions - "Do not draw blood in L[eft] arm at this time... do not take blood pressure in L arm... Monitor/document/report to health care provider PRN any s/s of infection to access site: Redness, swelling, warmth or drainage... observe for dry skin and apply lotion as needed."</p> <p>Neither the dialysis care plan nor clinical record included direction to staff or documentation that staff performed daily assessments, treatments, or monitoring to the resident's left arm fistula or</p>	F 279	<p>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>F279:</p> <ol style="list-style-type: none"> 1. Resident #9's care plan related to dialysis was updated. 2. All resident receiving dialysis have the potential to be affected by this practice and will have their care plans audited. 3. The QAPI process identified the root cause of the deficiency as the lack of development of the dialysis care plan. All licensed nurses will be educated on dialysis site care. The care team will be educated on care planning for dialysis site monitoring. 4. The DNS or designee will audit the care plans related to dialysis weekly x4, monthly x1 and quarterly x1. All audit findings will be reported to the QAPI Committee for further monitoring and modification. 5. Corrective action will be completed by June 6, 2016. 		

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

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F 279	Continued From page 4 central line port dialysis sites. A hospital discharge summary, dated 3/22/16, documented Resident #9's central line port site was infected with MSSA that spread to the left shoulder. Resident #9 required 4 weeks of intravenous antibiotic therapy through a PICC line specially placed in the hospital for the intravenous antibiotic therapy. On 4/15/16 at 7:40 am, Resident #9 stated, "The nurses monitor my site [resident was pointing to her left arm] with the dressing on and watch to make sure it's okay, no bleeding, and then they remove the dressing." Resident #9's care plan did not include instructions for dressing changes. On 4/15/16 at approximately 9:30 am, LPN #7 stated only RNs in the facility were authorized to assess, provide treatments for, and document on dialysis-related cares. Resident #9's care plan related to dialysis did not include specific interventions, with associated time frames for completion or care and monitoring of the resident's dialysis access sites.	F 279			
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	F 315		6/6/16	

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F 315	<p>Continued From page 5 normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and record review, it was determined the facility failed to ensure the ability of residents to safely self-catheterize was assessed and residents were provided adequate catheter care. This was true for 2 of 3 residents (#1 and #2) reviewed for urinary catheters. These failed practices created the potential for more than minimal harm should Resident #1 fail to self-catheterize in a safe manner or Resident #2 develop an urinary tract infection from inadequate catheter care. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 3/21/16 with diagnoses that included paraplegia, lack of bladder sensation, and UTI.</p> <p>The admission MDS assessment, dated 3/21/16, documented the resident was cognitively intact, had no upper extremity limitations, and required 1 staff member's limited assistance for voiding.</p> <p>Physician Orders, dated 3/21/16, documented Resident #1 was to receive Oxybutynin Chloride ER 5 mg as needed for bladder spasms and "feeling of incomplete bladder emptying," and Minocycline HCL 100 mg [antibiotic] daily and Nitrofurantoin Macrocrystal 100 mg [antibiotic] daily for UTI.</p> <p>Resident #1's care plan for April 2016, initiated 4/7/16, documented: * Focus - "Alteration in urinary elimination r/t</p>	F 315	<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:</p> <p>1. a. Resident #1 was assessed and found to be able to self-catheterize in a safe manner. b. Resident #2's care plan was updated to instruct CNA staff to perform catheter care and charting was enabled.</p> <p>2. All residents who have indwelling catheters in place or who self-catheterize have the potential to be affected by this practice and will be audited.</p> <p>3. The QAPI process identified the root causes of the deficiency as the lack of nurse education on the assessment of self-catheterization and care planning catheter care. All licensed nurses will be</p>		

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F 315	<p>Continued From page 6</p> <p>neurogenic bladder and uses self cath[eter] technique." * Goal - "[Resident #1] will remain free of side effects of complications r/t altered urinary elimination ..." * Interventions - "[Resident #1] prefers to perform self cath[eter] r/t neurogenic bladder...is able to make needs known and will request assistance as needed."</p> <p>Resident #1's clinical record did not include documentation of education, safety assessment, or performance evaluation related to his ability to safely and effectively self-catheterize.</p> <p>On 4/13/16 at 9:45 am, the DNS and the ROC said they would attempt to locate the self-catheterizing safety assessment and/or education documentation.</p> <p>On 4/13/16 at approximately 4:55 pm, Resident #1 stated, "A nurse [describing the DNS] was in here a couple hours ago and watched me [self-catheterize] and said that I did it right." Resident #1 then showed how he could access the straight catheterization kit from a bedside table next to his bed.</p> <p>A follow up request for the self-catheterization safety assessment and/or education documentation was made to Administrator, AIT, and DNS on 4/13/16 at 6:00 pm.</p> <p>On 4/14/16 at 7:50 am, the DNS provided a Progress Note, dated 4/13/16 at 4:31 pm, that documented, "Resident able to preform [sic] clean catheterization method to urinary bladder, utilizing and verbalizing the importance of safe</p>	F 315	<p>educated on assessing a resident's ability to perform their own self-catheterization. The care team will be educated on care planning for catheter care on all residents who have catheters in place.</p> <p>4. The DNS or designee will audit the care plans relating to catheter care and the corresponding documentation weekly x4, monthly x2 and quarterly x2. All audit findings will be reported to the QAPI Committee for further monitoring and modification.</p> <p>5. Corrective action will be completed by June 6, 2016.</p>		

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F 315	<p>Continued From page 7</p> <p>methods to avoid injury and or infection during process. Will review quarterly to ensure that resident maintains proper safety and clean methods avoiding injury and or infection."</p> <p>2. Resident #2 was admitted to the facility on 3/22/16 with multiple diagnoses including urinary retention, acute prostatitis (acute inflammation of the prostate), and dementia.</p> <p>Resident #2's 3/29/16 admission MDS assessment coded a BIMS score of 2 (severe cognitive impairment), extensive assistance of 1 person for personal hygiene, and indwelling urinary catheter in place.</p> <p>Resident #2's care plan for the indwelling catheter documented "a 16 French catheter" was in place on 3/22/16. The interventions on the care plan did not include catheter care.</p> <p>Resident #2's Order Summary Report, printed 4/12/16, included a 3/22/16 order to schedule an urology appointment within 1 to 2 weeks for "urinary obstruction with Foley [brand name] catheter in place."</p> <p>The urology appointment took place 4/12/16. The urologist continued the indwelling catheter and scheduled Resident #2 for prostate surgery on 4/20/16.</p> <p>Resident #2's MARs and TARs for March and April 2016 did not include catheter care. In addition, Progress Notes, dated 3/22/16 through 4/13/16, documented catheter care was provided on 3/24/16. The other Progress Notes did not include documentation of catheter care.</p>	F 315			

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F 315	Continued From page 8	F 315			
F 323 SS=D	<p>On 4/12/16 at 4:15 pm, RNCM #1 reviewed Resident #2's electronic medical record and said catheter care was not care planned and that catheter care was not documented. The RNCM said the care plan would be revised immediately and catheter care would be provided.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure staff consistently used a gait belt, as care planned, to transfer 1 of 12 sample residents (#3). The deficient practice created the potential for more than minimal harm from possible falls for residents who required the use of a gait belt for transfers. Findings included:</p> <p>Resident #3 was admitted to the facility on 2/20/16 with multiple diagnoses including a right hip fracture.</p> <p>The PPS 5-day schedule and admission MDS assessments, dated 2/26/16 and 3/10/16 respectively, coded the resident with severe cognitive impairment but usually able to</p>	F 323	<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>	6/6/16	

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F 323	Continued From page 9 understand others and to be understood by others, extensive 2-person assistance for transfers, and functional limitation in one lower extremity. The 3/10/16 MDS assessment also coded the use of a w/c and a walker. The resident's care plan for transfers, revised 4/6/16, documented, "[Resident #3] requires 1 staff assistance with walker and gait belt." On 4/13/16 at 9:15 am, Resident #3 was observed in a w/c in the doorway of the restroom in the resident's room. CNA #4, who was present at the time, assisted Resident #3 to stand by pulling up on the waist band of Resident #3's pants, and used verbal cueing and physical contact to assist the resident to use a walker to turn around and sit on the toilet. CNA #4 did not use a gait belt to transfer the resident. On 4/13/16 at 9:30 am, CNA #4 said she did not use a gait belt when she transferred Resident #3 from the w/c to the toilet.	F 323	F323: 1. CNA #4 was educated on the use of the gait belt and reading/reviewing the care plans for appropriate transfer status. 2. All residents who require a gait belt for transfers have the potential to be affected by this practice and will be audited. 3. The QAPI process identified the root cause of the deficiency as the need for additional CNA education for new employees regarding care plan review. Staff Development will enhance the training for CNAs on care plan review during orientation. All CNA staff will be educated on reviewing the care plan for proper transfer status. 4. The DNS or designee will audit resident transfers with gait belts weekly x4, monthly x4 and quarterly x2. All audit findings will be reported to the QAPI Committee for further monitoring and modification. 5. Corrective action will be completed by June 6, 2016.		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed	F 356		6/6/16	

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F 356	<p>Continued From page 10</p> <p>vocational nurses (as defined under State law).</p> <ul style="list-style-type: none"> - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to post current nurse staffing information. This failure affected 12 of 12 sample residents (#s 1-12), all other residents and visitors. Findings included:</p> <p>On 4/11/14 at 6:00 pm, a "Daily Staffing for Wednesday April 6, 2016" form was observed posted on a wall near the nurses' station. The nurse staffing information was 5 days old.</p> <p>On 4/11/16 at 6:10 pm, the Administrator and DNS were shown the 4/6/16 posted nurse staffing information and asked where nurse staffing information for 4/11/16 was posted. The</p>	F 356	<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</p>		

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

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F 356	Continued From page 11 Administrator said nurse staffing information for 4/11/16 was not posted and the information had not been posted since 4/6/15. The facility failed to ensure residents living in the facility, including sample residents #s 1-12, and visitors to the facility, had accurate information related to the number of RNs, LPNs and CNAs on duty and the total hours of each per shift.	F 356	7305 of the State Operations manual. F356: 1. Current nursing staffing information was posted in the designated area. 2. All residents have the potential to be affected by not posting the data. 3. The QAPI process identified the lack of a consistent process as the root cause of not posting the staffing data. A process will be developed to ensure the information is posted daily. The ward clerk and all licensed nurses will be educated on the new process. 4. The DNS or designee will audit the posting daily x7, weekly x3, and monthly x4. All audit findings will be reported to the QAPI Committee for further monitoring and modification. 6. Corrective action will be completed by June 6, 2016.		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431		6/6/16	

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F 431	<p>Continued From page 12 applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to ensure a medicated gel was not accessible to 1 of 12 sample residents (#7) and that expired stock medications were not available for resident use. The failures created the potential for more than minimal harm if Resident #7 ingested the medicated gel or applied it too often, and for decreased efficacy if expired medications were administered to residents. Findings included:</p> <p>1. Resident #7 was admitted to the facility in 2014 with multiple diagnoses including dementia and mental disorders.</p> <p>The most recent quarterly MDS assessment,</p>	F 431	<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>		

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F 431	<p>Continued From page 13 dated 3/10/16, coded the resident with a BIMS score of 4 (severe cognitive impairment) and independent ambulation in the resident's room.</p> <p>Resident #7's order Summary Report, dated 4/12/16, included an order for Benadryl gel 2% to the arms, trunk and/or legs topically PRN itching. The order was dated 3/29/16.</p> <p>Resident #7's MAR for April 2016, documented the most recent administration of PRN Benadryl gel was at 9:22 am on 4/8/16.</p> <p>On 4/13/16 at 9:45 am, a 32 ounce tube of Benadryl gel 2% was observed on Resident #7's bedside table.</p> <p>On 4/13/16 at 10:00 am, LN #3 accompanied the surveyor to Resident #7's room. LN #3 picked up the tube of Benadryl gel and said it "should not be left" in the resident's room. The LN said the tube of Benadryl gel was almost empty. LN #3 removed the tube of Benadryl gel from Resident #7's room.</p> <p>A 4/19/16 Internet search provided multiple websites regarding Benadryl gel.</p> <p>The website, nlm.nih.gov/medlineplus/druginfo/meds/a601044.html, last revised 8/15/14, documented, "Do not use more...of it [Benadryl gel] or use it more often than directed...Use just enough medication to cover the affected area...wash your hands after applying the medication."</p> <p>The website, fda.gov/NewsEvents/Newsroom/PressAnnounce</p>	F 431	<p>F431:</p> <ol style="list-style-type: none"> 1. a. The tube of Benadryl was immediately removed from resident #7's room. b. The expired stock medications were removed from the medication room. 2. All residents have the potential to be affected by this practice and will be audited. 3. The QAPI process identified the root cause of the expired stock medications as not having the medications reviewed for expiration on a monthly basis. The ointment left at the bedside was nurse error. A procedure will be developed for removing expired stock medications from the medication room. All licensed nurses will be educated on removing medications from residents' rooms following use and on the new procedure for monitoring expired stock medications. 4. The DNS or designee will audit medications at the bedside and expired meds in the med room weekly x4, monthly x4 and quarterly x2. All audit findings will be reported to the QAPI Committee for further monitoring and modification. 5. Corrective action will be completed by June 6, 2016. 		

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F 431	Continued From page 14 ments/ucm211773.htm, documented a 5/12/10 FDA Press Release which documented, "The U.S. Food and Drug Administration is warning consumers about potentially serious side effects from mistakenly swallowing Benadryl Extra Strength Itch Stopping Gel, an over-the-counter...product that should only be used on the skin...People swallowing the gel can ingest a dangerous amount of the active ingredient, diphenhydramine. Large doses...can result in...unconsciousness, hallucination, and confusion." 2. On 4/14/16 at 9:45 am, the Administrator accompanied the surveyor to review oral, liquid, and suppository medications in the medication room to assure there were no expired medications. Two Acetaminophen suppository boxes with expiration date of February 2016, five bottles of Cranberry Supplements with expiration date of March 2016, and one bottle of Calcium Carbonate that expired September 2015 were found during the review.	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		6/6/16	

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F 441	<p>Continued From page 15 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure staff consistently implemented standard hand hygiene infection control measures after toileting assistance for 1 of 12 sample residents (#3). The failure created the potential for the development of infection due to cross-contamination. Findings included: On 4/13/16 at 9:15 am, CNA #4 was observed as she assisted Resident #3 to use the toilet in the</p>	F 441	<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</p>		

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F 441	<p>Continued From page 16</p> <p>resident's restroom. When Resident #3 finished using the toilet, CNA #4 assisted the resident to stand, cleaned Resident #3's buttock area, and pulled up the resident's incontinence brief and pants. CNA #4 then touched Resident #3's arms and waist and placed the walker in front of Resident #3. CNA #4 assisted Resident #3 to use the walker to turn around, and to sit in a w/c. Resident #3 asked CNA #4 to wash the resident's hands. After that, CNA #4 removed her gloves and wet a wash cloth which she used to wipe Resident #3's hands. At that time, CNA #4 said Resident #3 had a small bowel movement. CNA #4 moved Resident #3 out of the restroom and the resident's room to the common/TV area near the nurses' station. CNA #4 did not wash her hands or use hand sanitizer after glove removal or before touching Resident #3 and handling the resident's items.</p> <p>Immediately afterward, two paper towel holders in Resident #3's restroom were observed to be empty and there were no hand towels in the restroom.</p> <p>On 4/13/16 at 9:30 am, CNA #4 said she did not sanitize or wash her hands after toileting Resident #3 and removing her gloves. CNA #4 said she sanitized her hands after she took the resident to the common/TV area. CNA #4 also said the paper towel holders in the resident's restroom were empty so she just wiped Resident #3's hands with a wet washcloth.</p> <p>The CDC Guideline for Hand Hygiene in Health-Care Settings - October 25, 2002/Vol. 51/No. RR-16, includes a guideline for staff to, "Decontaminate hands after removing gloves."</p>	F 441	<p>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>F441</p> <ol style="list-style-type: none"> 1. CNA #4 was educated on hand hygiene. 2. All residents have the potential to be affected by this practice. 3. The QAPI process identified the root cause as the inability of the CNA to troubleshoot under pressure. All CNAs will be re-educated on proper hand hygiene. 4. The DNS or designee will audit CNAs for appropriate hand hygiene weekly x4, monthly x4 and quarterly x2. All audit findings will be reported to the QAPI Committee for further monitoring and modification. 5. Corrective action will be completed by June 6, 2016. 		

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F 441	Continued From page 17 The same CDC Guideline also states, "Before eating and after using a restroom, wash hands with a non-antimicrobial soap and water or with an antimicrobial soap and water."	F 441			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, and record review, it was determined the facility failed to ensure complete and accurate documentation of cares was maintained for 2 of 15 residents (#s 1 and 9) whose clinical records were reviewed. This failed practice had the potential for more than minimal harm for Resident #1, whose Physical Therapy and Occupational Therapy documentation was incomplete, and for Resident #9, whose dialysis documentation did not include pre or post-assessment information and monitoring data required for the safe delivery of services. Findings include:	F 514	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	6/6/16	

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F 514	<p>Continued From page 18</p> <p>1. Resident #1 was admitted to the facility on 3/21/16 with orders for PT and OT to evaluate and treat.</p> <p>Resident #1's record was reviewed. The record did not include documentation of PT and OT evaluations or treatment.</p> <p>On 4/13/16 at 11:00 am, PT #9 and OT #10 were asked about the lack of documentation that Resident #1 had been screened or treated. PT #9 and OT #10 stated Resident #1 was screened for PT and OT services. They stated the facility's computerized records system was not able to record the screen and there were no orders written to continue with therapies as the resident already met his baseline goals. PT #9 and OT #10 stated exercise bands were provided for upper body strengthening, and noted, "There is nowhere to document, but we did communicate verbally to the nurse managers that the resident was screened only."</p> <p>On 4/13/16 at 5:00 pm, Resident #1 stated, "I refused to have therapy because I am here for wound care and I know if I feel like I am becoming weak, I can request therapy. They gave me therabands to work on my arms, which I use daily."</p> <p>2. Resident #9 was admitted to the facility on 2/28/16 with a diagnoses that included chronic kidney disease.</p> <p>Resident #9's admission MDS assessment and Physician Orders, both dated 2/28/16, documented the resident received dialysis three</p>	F 514	<p>compliance in accordance with section 7305 of the State Operations manual.</p> <p>F514</p> <p>1. a. Resident #1 was screened by PT and OT. b. Resident #9's TAR was updated to include site monitoring after dialysis treatment.</p> <p>2. All residents receiving therapy orders or dialysis care have the potential to be affected by this practice and will be audited.</p> <p>3. The QAPI process identified that the root cause of the therapy deficiency was the therapists are not providing written documentation of their screenings when they do not treat. All therapists will be educated on expected and proper documentation of services provided. The QAPI process identified the root cause of the lack of documentation was the education of the nurses on dialysis site monitoring. All licensed nurses will be educated on dialysis site care, fistula site observation, and related documentation.</p> <p>4. The DNS or designee will audit therapy orders/documentation and dialysis documentation daily x 7, weekly x3, monthly x4 and quarterly x2. All audit findings will be reported to the QAPI Committee for further monitoring and modification.</p> <p>5. Corrective action will be completed by June 6, 2016.</p>		

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 640 NORTH EISENHOWER STREET MOSCOW, ID 83843		
(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 514	<p>Continued From page 19 times a week on Mondays, Wednesdays, and Fridays.</p> <p>Resident #9's undated care plan documented: *Focus - "[Resident #9] needs hemodialysis Mon, Wed, Fri r/t renal failure." *Goal - "[Resident #9] will have no s/s of complications from dialysis..." *Interventions - "Do not draw blood in L[eft] arm at this time, Do not take blood pressure in L arm, Monitor/document/report to health care provider PRN any s/s of infection to access site: Redness, swelling, warmth or drainage, observe for dry skin and apply lotion as needed."</p> <p>Resident #9's clinical record, including the monthly MARs and/or TARs, did not include documentation that the dialysis site to the left arm or central catheter was assessed or monitored prior to or following dialysis treatments.</p> <p>On 4/15/16 at 7:40 am, Resident #9 stated, "The nurse monitors and feels my left upper arm before dialysis and gives me a communication sheet to give to the dialysis center to communicate back to the facility after dialysis. Returning from dialysis, the nurse will monitor my left upper arm and takes the dressing off in a couple of hours when there is no more bleeding."</p> <p>On 4/15/16 at approximately 9:30 am, LN #7 stated, "The RN does all the care and monitoring for the dialysis resident."</p> <p>On 4/15/16 at approximately 9:45 am, RN #6 stated, "The left upper arm fistula will be assessed for thrill and bruit and vital signs are checked and documented on the Dialysis</p>	F 514			

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

PRINTED: 06/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/15/2016
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F 514	Continued From page 20 Communication/ Referral sheet before she leaves for dialysis. Any significant changes or concerns regarding the resident will be written on that form. When the resident returns, a nurse will review the Dialysis Communication/Referral sheet for any new [physician] orders, assess the left upper arm dressing, check vital signs, then remove the dressing to her left upper arm in about 2-3 hours to ensure there are no signs or symptoms of bleeding or other complications." Resident #9's record did not include documentation of the activities described by RN #6, nor were they included in Resident #9's care plan.	F 514			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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May 20, 2016

Jamie Berg, Administrator
Good Samaritan Society-- Moscow Village
640 North Eisenhower Street
Moscow, ID 83843-9588

Provider #: 135067

Dear Ms. Berg:

On **April 15, 2016**, an unannounced on-site complaint survey was conducted at Good Samaritan Society-- Moscow Village. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006914

ALLEGATION #1:

The Reporting Party stated the identified resident did not have a "definitive plan of care" for five days after admission to the facility.

FINDINGS #1:

The identified resident's clinical record included a Care Plan addressing twelve specific areas of concern. The Care Plan included focus areas with initiation and revision dates, goals with target dates, and interventions with initiation and revision dates.

The facility was cited for deficient practice related to the development of an initial Care Plan for a resident other than the identified resident who is the subject of this allegation. Please refer to F279 on Federal Report 2567 for details.

Based on observation, interview, and record review, it was determined the facility failed to ensure assess the resident (#9) fistula to left upper arm before and after dialysis care and daily assessments. This is true for sample one of one. This failed practice created potential for more than minimal harm should complications occur. Findings include:

Resident #9 was admitted to the facility on 2/28/16 with diagnosis that included chronic kidney disease. Resident was re-admitted on 3/22/16 with diagnoses that included chronic kidney disease and MSSA infection.

The admission MDS assessment, dated 2/28/16, documented the resident was receiving hemodialysis three times a week. The 3/22/16 re-admission MDS assessment was carried forward from 2/28/16.

Physician Orders, dated 2/28/16, documented to receive Dialysis every Monday, Wednesday, and Friday. On re-admission date 3/22/16, documented PICC line dressing change every week, flush PICC line every shift, and Cefazolin Sodium Solution Reconstituted 1 GM, Use 2 gram IV daily until 4/12/16.

Resident #9's undated care plan documented:

*Focus - "Hemo dialysis Mon, Wed, Fri r/t renal failure."

*Goal - "(###) will have no s/s of complications from dialysis..."

*Interventions - "Do not draw blood in L arm at this time... do not take blood pressure in L arm... Monitor/document/report to health care provider PRN any s/s of infection to access site: Redness, swelling, warmth or drainage... observe for dry skin and apply lotion as needed."

Resident #9's Nursing Admit Re-Admit Data Collection, stated the reason Resident #9 was admitted because she was hospitalized or received services at hospital, and "renal failure, stage 3 pressure ulcer."

The resident's clinical record did not include daily assessments, treatments, or monitoring to left arm fistula related to dialysis.

On 4/15/16 at 7:40 am, the resident stated, "The nurses monitor my site (###) with the dressing on and watch to make sure "it's okay, no bleeding", and then they remove the dressing."

On 4/15/16 at approximately 9:30 am, spoke with LPN on assessment and care of fistula to left arm before and after dialysis. The LPN stated that the RN takes care of all the assessments, care, and documentation.

On 4/15/16 at approximately 9:45 am, spoke with RN on assessment and care of the fistula to left arm before and after dialysis. The RN stated, "Resident #9 had Vital Signs checked and

documented any significant changes since last dialysis treatment to the Dialysis Communication/Referral document and will send the document with the resident to dialysis to have dialysis fill out and return with Post-Dialysis Instructions as needed. When resident returns to the facility, the nurse will assess the dressing to left arm for s/s bleeding or complications and will remove the dressing to the left arm fistula site in a few hours."

Federal guidance at F279 483.20(k)(1) documented, "The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The requirements reflect the facility's responsibilities to provide necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care..."

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2

The Reporting Party stated the identified resident did not have "definitive active therapies" for five days after admission to the facility.

FINDINGS #2

The identified resident's clinical record included Physician's Orders, dated March 3, 2015, that documented the facility's Physical Therapy, Occupational Therapy, and Speech Therapy services were to evaluate and provide therapies as indicated. The identified resident's Care Plan also included interventions, dated March 5, 2015, directing staff to encourage the resident's participation in activities that promoted exercise, as well as physical activity for strengthening and improved mobility such as Physical Therapy, Occupational Therapy, and "exercise group."

This allegation is unsubstantiated due to lack of sufficient evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The Reporting Party stated the identified resident did not have a "Concrete History and Physical" up to five days after admission to the facility.

Jamie Berg, Administrator
May 20, 2016
Page 4 of 4

FINDINGS #3

The identified resident's clinical record included a History and Physical signed by a facility physician that attested the document had been reviewed by the physician on March 4, 2015.

This allegation could not be substantiated due to a lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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 questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., 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,

Nina Sanderson, L.S.W., Supervisor
Long Term Care

NS/lj



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July 22, 2016

Jamie Berg, Administrator
Good Samaritan Society-- Moscow Village
640 North Eisenhower Street
Moscow, ID 83843-9588

Provider #: 135067

Dear Ms. Berg:

On **April 15, 2016**, an unannounced on-site complaint survey was conducted at Good Samaritan Society-- Moscow Village. The complaint was investigated during the facility's on-site Federal Recertification and State Licensure survey conducted April 11, 2016 to April 15, 2016.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007172

ALLEGATION #1:

Staff referred to an identified resident as "the bitch" or "the bat" within hearing distance of others.

FINDINGS #1:

Immediately after entering the facility on April 11, 2016, the survey team conducted a tour of the facility, including common areas and resident rooms. Throughout the survey, the residents' environment and the staff's interactions with residents in general were observed. In addition, two meal observations were conducted and twelve individual residents were observed for quality of life and quality of care issues.

Jamie Berg, Administrator
July 22, 2016
Page 2 of 5

The clinical records of the identified resident and fourteen other residents were reviewed regarding various issues, including quality of life and quality of care. The facility's grievance files, incident and accident reports, investigations of allegations of abuse, and staffing records were also reviewed.

Interviews were conducted with four individual residents, two resident representatives, and three residents in a Resident Group. The Administrator, Administrator in Training, Director of Nursing Services, Licensed Nurses, Certified Nursing Assistants, Social Worker, and the Regional Operations Consultant were also interviewed.

Based on the interviews, observations, and record reviews, there were no voiced or written concerns that staff addressed residents by derogatory names. The residents commented that staff were "great" and treated them "really good." Deficient practice was not identified; therefore, the allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The staff shut an identified resident in her room and she shouts until she is hoarse.

Residents are treated "horribly," mostly by Certified Nursing Assistants, and Licensed Nurses are not responsive when concerns are brought to their attention.

Residents lay in bed all day because staff "forgets" to get them out of bed.

An unidentified resident was told to be quiet when she wandered to the nurses desk and asked staff to talk to her.

FINDINGS #2:

Based on observations, interviews, and record reviews, residents said staff treated them with respect and were willing to listen if they wanted to talk about something or had a problem. The residents said the staff made efforts to resolve problems if they knew about them. The residents said they could choose how they spent their day and they could get up or lie down when they wanted to and staff provided assistance when it was needed.

Staff were observed being congenial and respectful when providing personal care and when interacting with residents in general. Several staff were observed as they assisted residents out of

bed or to lay down, usually after a meal.

No resident was observed laying in bed all day without staff requests and encouragement for them to get out of bed. Some residents chose to have their doors closed, but none of the residents were "shut" in their room. In addition, there were no concerns, voiced or written, that residents were left in bed or shut in their room.

There was no voiced, written, or observed evidence that staff neglected residents, Certified Nursing Assistants treated residents "horribly," Licensed Nurses did not respond when informed of concerns, staff forgot to get residents out of bed, staff isolated any resident, or that staff hushed residents who wanted to talk to them. Deficient practice was not identified and the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

An identified resident is "so drugged up now" he/she doesn't know his/her own name.

FINDINGS #3:

Based on interviews, observations, and record reviews, medications were administered to residents according to physicians' orders and accepted standards of practice. In addition, there were no voiced or written concerns that residents had been or were being "drugged up." Deficient practice was not identified and the allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Feces on an identified resident's floor is left for long periods of time before it is cleaned up.

FINDINGS #4:

Record review revealed that the identified resident did throw feces on the floor. However, based on the initial tour of the facility and observations throughout the survey, as well as interviews with residents, resident representatives, and staff, the resident's room was cleaned in a timely manner. In addition, there were no voiced or written concerns that feces was left on the floor for

long periods. Deficient practice was not identified and the allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

An identified resident experienced a non-injury fall on October 2, 2015 and a Licensed Nurse suggested the family not be notified to avoid filling out an incident report and changing the Care Plan.

FINDINGS #5:

The identified resident's clinical record documented that a family member was notified within two hours of a non-injury fall. In addition, based on the interviews with residents, resident representatives, and staff, as well as review of other records, including the clinical records of other residents, Incident and Accident reports, and grievance files, there were no voiced or written concerns that facility staff failed to notify family members of resident falls in order to avoid completing incident reports. Deficient practice was not identified and the allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The facility has inadequate staffing levels.

FINDINGS #6:

Based on interviews with residents, resident representatives, and staff, as well as review of residents' clinical records, nursing staffing schedules and actual hours worked, and observations during the survey, the facility exceeded the required minimum nurse staffing hours. In addition, the residents interviewed said that staff responded promptly to call lights and consistently met their needs. Deficient practice was not identified and the allegation was not substantiated.

ALLEGATION #7:

Residents are sometimes put into beds soaked with urine/feces.

Jamie Berg, Administrator
July 22, 2016
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FINDINGS #7:

Based on record review, the identified resident frequently picked apart his/her incontinence brief and smeared feces and/or the wet brief onto the bed and bed linens. In addition, based on observations and interviews with residents and staff, soiled bed linens were changed promptly and there were no grievances that residents had been or were being put into beds with soiled bed linens. Deficient practice was not identified and the allegation was not substantiated.

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.

Sincerely,

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

David Scott, RN, Supervisor
Long Term Care

DS/lj