



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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CERTIFIED MAIL: 7007 3020 0001 4044 7427

March 27, 2013

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

Provider #: 135085

Dear Mr. Davidson:

On **March 15, 2013**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Good Samaritan Society - Boise Village by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, 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

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sign both 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 **April 9, 2013**. Failure to submit an acceptable PoC by **April 9, 2013**, may result in the imposition of civil monetary penalties by **April 29, 2013**.

The components of a Plan of Correction, as required by CMS include:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- Include dates when corrective action will be completed in column 5.

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.

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- 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 **April 19, 2013 (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 **April 19, 2013**. A change in the seriousness of the deficiencies on **April 19, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 19, 2013** includes the following:

Denial of payment for new admissions effective **June 15, 2013**. [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 **September 15, 2013**, 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, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; 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.

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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 **March 15, 2013** 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)

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

This request must be received by **April 9, 2013**. If your request for informal dispute resolution is received after **April 9, 2013**, 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, please contact us at (208) 334-6626.

Sincerely,



LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj
Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135085	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 3/15/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - BOISE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 SYCAMORE DRIVE BOISE, ID	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 278	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure an MDS assessment accurately reflected a resident's status. This was true for 1 of 11 residents (#2) reviewed for MDS assessment completion. Findings included:</p> <p>Resident #2 was admitted to the facility on 8/20/11 with multiple diagnoses including dementia and anxiety.</p> <p>The resident's Significant Change MDS assessment, dated 1/11/13, coded the resident as having no falls since the last Quarterly MDS assessment, dated 10/23/12.</p> <p>A facility Incident Report dated 11/27/12, documented the resident had a fall on 11/27/12 at the facility.</p> <p>On 3/13/13 at 9:00 AM, the Harbor Unit Care Manager was interviewed regarding the MDS issue. She stated, "It must have been a missed key punch...certainly not intentional."</p> <p>Despite the inaccurate MDS, the Resident Care Area Assessment dated 1/11/13, did trigger for falls and was care planned.</p> <p>On 3/14/13 at 2:05 PM, the Administrator and DON were informed of the issue. No other information was provided by the facility.</p>		

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

The above isolated deficiencies pose no actual harm to the residents

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

PRINTED: 03/25/2013
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 03/15/2013
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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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual recertification and complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were: Karen Marshall, MS, RD, LD Team Coordinator Monica Nielsen, QMRP, MEd Loretta Todd, RN, BSN Karla Gerleve, RN Brad Perry, BSW, LSW</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status BP = Blood Pressure BSW = Bachelors Social Work CAA = Care Area Assessment CNA = Certified Nurse Aide DNS/DON = Director Nursing Services/Director of Nursing LN = Licensed Nurse LSW = Licensure Social Worker MAR = Medication Administration Record MDS - Minimum Data Set assessment PEG - Percutaneous Endoscopic Gastrostomy - a tube inserted through the abdominal wall into the stomach for administering medications and/or nutrition. POC = Plan of Care RAI = Resident Assessment Instrument RAPS = Resident Assessment Protocol Summary TAR = Treatment Administration Record</p>	F 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 style="text-align: center;">RECEIVED APR 08 2013</p> <p style="text-align: center;">FACILITY STANDARDS</p>	
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable</p>	F 246	<p>F246 – Reasonable Accommodation of Needs / Preferences</p> <p><u>Resident Specific</u></p>	4/12/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 4/8/13
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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.

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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		
(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 246	<p>Continued From page 1 accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined the facility failed to provide reasonable accommodation of individual needs. This was true for 1 of 15 (#4) sampled residents and 1 (#20) random resident. The facility failed to ensure Resident #4's and Resident #20's call lights were accessible to them. This had the potential for physical and psychological harm to the residents whose call lights were needed or wanted, and were not accessible to them. Findings included:</p> <p>On 3/11/13 at 1:35 PM, Resident #4 was observed sitting in his wheelchair the foot of his bed, in his room. Resident #4 indicated he was ready to lay down, but he could not reach his call light. The call light was observed hanging on the left side of the bed, but the over bed table was up against the bed, blocking access to the call light.</p> <p>On 3/11/13 at 1:38 PM, Resident #20 was observed laying in bed. He stated "Can you get me some water?" He also stated he could not reach his call light. His call light was observed on his bed above his head.</p> <p>On 3/11/13 at 1:45 PM in the resident's room, CNA #1 acknowledged Resident #20's call light was not in the resident's reach. She moved the</p>	F 246	<p>The call lights for residents #4 and #20 were placed in locations accessible to the residents.</p> <p><u>Other Residents</u></p> <p>All residents have the potential for physical and psychological harm whose call lights are not accessible. A complete audit of all call lights was completed to ensure each call light is accessible.</p> <p><u>Facility System</u></p> <p>The caregiver who failed to ensure the call lights were accessible for residents #4 and #20 was re-educated. In-servicing was completed for all nursing staff on 3/25, 3/26, 3/28, 3/29, 4/2, 4/3, and 4/4/13 related to call light accessibility.</p> <p><u>Monitor</u></p> <p>The RN care managers will audit to ensure the proper positioning of call lights weekly x4, bi-weekly x2, and monthly x3. Audit results will be reported to the monthly QI meeting for further monitoring and plan modification.</p> <p><u>Date of Compliance</u></p>	

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F 246	Continued From page 2 call light from above the resident's head and placed it on the resident's chest. On 3/14/13 at 11:35 PM, Resident #4 was observed sitting in his wheelchair, at the foot of his bed, in his room. The call light was on the left side of the bed, under the covers, with the over bed table up against the bed. Again, the call light was not accessible to Resident #4.	F 246	April 12, 2013	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F280 – Right to participate in the care planning process / Revising the care plan <u>Resident Specific</u> Resident #5's care plan was revised to include female caregivers and dining needs. Resident #12 has been on leave of absence since 1/25/13 and discharged on 3/29/13. <u>Other Residents</u> RN care managers have reviewed care plans for all residents to ensure they are current and comprehensive. <u>Facility System</u> Nursing and social services have been in-serviced on 3/25, 3/26, 3/28, 3/29,	4/12/13

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F 280	<p>Continued From page 3</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 care plans were evaluated and revised as the resident's requests, needs, or status changed. This affected 2 of 12 (#s 5 & 12) sampled residents. This failure created the potential for staff to not provide Resident #12 protection from potentially inappropriate actions by an identified family member. For Resident #5, this created the potential for the resident's request for female caregivers and dining needs to not be met. Findings included:</p> <p>1. Resident #12 was originally admitted to the facility 5/1/12, and readmitted on 9/13/12, with multiple diagnoses including traumatic brain injury.</p> <p>Resident #12's 9/12/12 significant change MDS coded</p> <ul style="list-style-type: none"> - severe cognitive impairment and minimal depression - minimum of one person extensive assistance for ADLs - upper and lower extremity range of motion limitations - inattention and disorganized thinking - antianxiety and antidepressant medications <p>The resident's Face Sheet contained documentation, handwritten, "[name of family member and relationship] do not call, call guardian."</p> <p>The resident's 7/27/12 nursing home visit report, signed by his attending physician, documented, in</p>	F 280	<p>4/2, 4/3, 4/4, and 4/11/13 regarding care plans to ensure they are current and comprehensive for each resident.</p> <p><u>Monitor</u></p> <p>The RN care managers and social services will audit care plans weekly x4, bi-weekly x2, and monthly x3 to ensure they are current and comprehensive. Audit results will be reported to the monthly QI meeting for further monitoring and plan modification.</p> <p><u>Date of Compliance</u></p> <p>April 12, 2013</p>	

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F 280	<p>Continued From page 4</p> <p>part, "...There have been problems with his [identified family member] who has come into the facility and apparently left or given [Resident #12] lorazepam [Ativan], unbeknownst to the staff. He probably was a bit more sedated than he should have been and subsequently the [identified family member] now been {sic} banned from coming into the facility. Since that has taken place, [Resident #12] is doing quite well. [Resident #12] has also indicated that he is not necessarily interested in seeing his [identified family member]..."</p> <p>Review of Resident #12's Comprehensive Care Plan did not provide evidence the facility identified needs, plans or approaches to address potentially inappropriate actions by an identified family member.</p> <p>On 3/14/13 at 10:22 a.m., the surveyor informed the Administrator and the DON of the concern regarding Resident #12's identified family member and what actions were taken by the facility.</p> <p>On 3/14/13 at 11:30 a.m., the DON and Social Services #4 provided the survey team with a copy of a police report, actions taken by the facility involving the resident's guardian, guardian's lawyer, a local guardian services company, and other additional information. None of the information provided, included updates to the resident's care plan to identify needs, plans or approaches to address the potentially inappropriate actions by an identified family member. The DON stated, "We do not have that [an updated care plan for the resident for the potentially inappropriate actions of an identified</p>	F 280		

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F 280	<p>Continued From page 5 family member]."</p> <p>On 3/15/13 at 11:00 a.m., the Administrator and the DON were informed of the finding.</p> <p>2. Resident #5 was admitted to the facility on 8/1/12 with multiple diagnoses including encephalopathy and schizoaffective disorder.</p> <p>The resident's 1/23/13 quarterly MDS coded severely impaired cognitive skills, moderately severe depression, and required one person physical assistance for ADLs.</p> <p>a. On 11/1/12, an investigation on behalf of the resident was conducted by the facility to rule out abuse. The investigation results determined, in part, the resident had a preference for female caregivers.</p> <p>On 3/12/13 at 8:33 a.m., two CNAs (#s 5 & 6) were observed providing cares for the resident. At 8:34 a.m., another staff member knocked on the door and a male voice was heard, "Is everything good in there?" Both CNAs answered, "Yes." At 8:35 a.m., Resident #5 asked the CNAs if there was a man in the room. CNA #6 told the resident the male voice was just asking if everything was okay. CNA #6 said, "I must have accidentally pushed the call light."</p> <p>b. On 3/11/13 at 11:50 a.m. and again on 3/12/13 at 7:25 a.m., the resident was observed in the main dining room and assisted by one staff member. The resident's plate had a metal plate guard. The resident's meal/diet card contained the words "plate guard."</p>	F 280		

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F 280	Continued From page 6 Review of Resident #5's Comprehensive Care Plan did not provide evidence the resident was care planned for female caregivers whenever possible or for the use of a plate guard. On 3/13/13 at 9:45 a.m., the surveyor informed the Unit Care Manager the care plan did not include an intervention of female caregivers whenever possible or the use of a plate guard. The Unit Manager stated, "The person in charge of dietary services and I contacted therapy. Therapy recommended the use of a plate guard when the resident resided in another unit of the facility. The resident has requested female caregivers whenever possible. I will update the care plan."	F 280		
F 314 SS=G	On 3/15/13 at 11:00 a.m., the Administrator and the DON were informed of the finding. 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure a resident with pressure sores received	F 314	F314 – Treatment / Services to prevent / Heal Pressure Sores <u>Resident Specific</u> A ROHO cushion has been implemented to the wheelchair for Resident #4. <u>Other Residents</u> All resident care plans have been reviewed to ensure appropriate wheelchair cushions and other necessary treatment and services are in place to promote healing, prevent infection and prevent new sores from	4/12/13

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F 314	<p>Continued From page 7</p> <p>necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This was true for 1 of 6 sampled residents (#4) reviewed for pressure ulcers and at high risk for pressure ulcers. The facility failed to implement a ROHO Cushion to the wheelchair which was specified by the care plan. This failed practice resulted in harm when Resident #4 developed a re-current pressure sore to the ischium and placed the resident at further risk for skin breakdown, pain, and infection. Findings included:</p> <p>Resident #4 was admitted to the facility on 9/9/10 with diagnoses of pressure ulcer left ischial stage IV, atrial fibrillation, prostate cancer, pain, hypertension, dementia with depression, diabetes mellitus type II, peripheral vascular disease, and chronic obstructive pulmonary disease.</p> <p>Resident #4's most recent annual MDS assessment dated 7/31/12 coded, in part:</p> <ul style="list-style-type: none"> * BIMS Score: 7 * extensive assistance for bed mobility and transfer, * wheelchair for mobility device * at risk for pressure ulcer at stage I or higher * 1 stage III pressure ulcer * granulation tissue appearance was most severe tissue type of any pressure ulcer * pressure reducing device for chair * pressure reducing device for bed * turning and repositioning program * nutrition or hydration intervention to manage skin problems * application of nonsurgical dressings * applications of ointments/medications 	F 314	<p>developing.</p> <p><u>Facility System</u></p> <p>Nursing was in-serviced on 3/25, 3/26, 3/28, 3/29, 4/2, 4/3, and 4/4/13 to ensure proper cushions are on wheelchairs specific to each resident's care plan needs. Each cushion has been labeled specific to resident chair so staff knows what chair the cushion belongs to. The evening and night shift nurses will audit cushions and chairs for compliance.</p> <p><u>Monitor</u></p> <p>The RN care managers will audit care plans and wheelchair cushions weekly x4, bi-weekly x2, and monthly x3 to ensure they are being appropriately placed. Audit results will be reported to the monthly QI meeting for further monitoring and plan modification.</p> <p><u>Date of Compliance</u></p> <p>April 12, 2013</p>	

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F 314	<p>Continued From page 8</p> <p>Resident #4's most recent quarterly MDS assessment dated 1/15/13 coded, in part:</p> <ul style="list-style-type: none"> * BIMS Score: 7 * extensive assistance for bed mobility and transfer * wheelchair for mobility device * at risk of developing pressure ulcers * pressure reducing device for chair * pressure reducing device for bed * turning repositioning program * nutrition or hydration intervention * Note: There was no existing pressure ulcer coded <p>Resident #4's care plan, dated 1/29/13, identified the problem, "Skin impairment r/t non healing lt [left] IT [ischial] P.U. [pressure ulcer]....."Approaches implemented included: *"CK [check] skin daily with AM/PM cares report concerns to LN [license nurse]</p> <ul style="list-style-type: none"> *Turn & [and] reposition Q HR & PRN QS [every 1 hour and as needed every shift]side to side only off load heels *Low air loss alternating pressure mattress to bed *Rigid bottom with ROHO cushion to wc [wheelchair]" <p>Resident #4's "WOUND FLOW SHEET" dated from 9/13/12 to 10/11/12, indicated a "Stage 3 pressure area located on the left ischium". It stated the "area closed" on 9/20/12.</p> <p>Resident #4's "WOUND FLOW SHEET" dated 11/26/12 to 12/27/12, indicated a "Stage 2 pressure ulcer located on the left buttock". It stated "area is a reopening of a previous pressure ulcer. Reopening was expected" on</p>	F 314			

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F 314	<p>Continued From page 9 11/26/12.</p> <p>Resident #4's "WOUND FLOW SHEET" dated 2/13/13, indicated a pressure ulcer, but did not indicate a stage or location. It stated the area, "closed" on 2/21/13.</p> <p>On 3/11/13 at 11:50 AM and at 1:35 PM, Resident #4 was observed sitting in his wheelchair in the dining room.</p> <p>On 3/12/13 at 7:25 AM, the resident was also observed in his wheelchair, smoking out on the patio.</p> <p>On 3/12/13 at 12:45 PM, the DON was asked about Resident #4's reoccurring ischial pressure ulcer. The DON indicated the resident was admitted with the pressure ulcer and indicated the pressure ulcer was nonhealing and reoccurring. She agreed to provide further documentation. At 2:00 PM the DON provided documentation of the resident's smoking, some refusals of care, physicians visits, and Wound Flow Sheets. However the documentation was conflicting and indicated the ischial wound was non-healing, had closed, and had healed.</p> <p>On 3/12/13 at 1:48 PM, the MDS Coordinator/Rehab (Rehabilitation) RN was interviewed in Resident #4's room. Upon touching the cushion, the MDS Coordinator/Rehab RN stated the cushion was a, "Keen contour plus foam cushion". The cover to the cushion had on it, the words "Keen contour plus foam". Note: The care plan specified a ROHO cushion, not a Keen contour plus foam cushion.</p>	F 314		

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F 314	<p>Continued From page 10</p> <p>On 3/13/13 at 9:00 AM, the Physical Therapist #3 was interviewed in the Physical Therapy room. He stated "The ROHO cushion was better for pressure relief" and "The ROHO cushion was a grade above the Keen contour plus foam cushion."</p> <p>On 3/13/13 at 11:40 AM, the RN Care Manager on Syringa II Unit was interviewed. She indicated she did not know when the wheelchair cushion was changed from the ROHO cushion. She stated, "I believe it may have occurred when the wheelchair was washed."</p> <p>On 3/14/13 at 1:30 PM, the MDS Coordinator/Rehab RN was interviewed in her office. She indicated that she or therapy frequently put cushions on resident's wheelchairs, but she did not know when Resident #4's cushion was changed or who may have changed the cushion from the ROHO cushion to the Keen contour plus foam cushion.</p> <p>The facility failed to implement the ROHO cushion to Resident #4's wheelchair, as specified by the care plan. This failed practice harmed the resident when his pressure ulcer reopened on 11-26-12.</p> <p>On 3/14/13 at 2:00 PM, the Administrator and DON were informed of the pressure ulcer issue. However, no other information or documentation was received from the facility.</p>	F 314		
F 322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident</p>	F 322	<p>F322 – NG tube Treatment / Services to Restore Eating Skills</p> <p><u>Resident Specific</u></p>	4/12/13

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F 322	<p>Continued From page 11</p> <p>who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</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 provide appropriate care to a resident with a feeding tube when staff were observed to give double the amount of tube feeding solution as was ordered by the physician. This was the case for 1 of 3 residents (#7) reviewed for tube feeding care with administration of medications. This created the potential that Resident #7 would experience nausea/vomiting related to the large volume of solution administered in a bolus at one time. Additionally, expired tube feeding solution was found in the Syringa 1 medication room. Findings include:</p> <p>1. On 03-11-13 at 11:51 am, LN #7 was observed to administer three medications and Osmolyte 1.5cal to Resident #21. LN #7 indicated that the Osmolite was ordered to be given a half can earlier in the morning and a half can at noon, but that 'we usually give a whole can at once.' She then administered a whole 8-ounce can of Osmolite 1.5Cal through Resident #7's PEG tube. The Osmolite was administered by pouring the solution into a syringe that was connected to the PEG tube. It infused in approximately two minutes by gravity feed.</p>	F 322	<p>LN #7 was re-educated for failure to follow MD orders when administering Osmolite through a feeding tube. The 2 cans of Jevity 1.5 cal with an expiration date of 1-1-13, 4 cans of Jevity 1.5 cal with an expiration date of 2-1-13 and a large container of Pivot 1.5 tube feeding solution with an expiration date of 3-1-13 were discarded on 3/12/13.</p> <p><u>Other Residents</u></p> <p>All residents' order sheets have been reviewed to ensure Osmolite is being administered according to MD orders. All medication rooms were searched to ensure no expired medications or supplies were present.</p> <p><u>Facility System</u></p> <p>Nursing was in-serviced on 3/25, 3/26, 3/28, 3/29, 4/2, 4/3, and 4/4/13 related to administering Osmolite via tube according to MD orders and checking expiration dates for medications and supplies in medication rooms. If any items are found to be expired, they are to be discarded of appropriately.</p> <p><u>Monitor</u></p> <p>The RN care managers will audit the nurses administering Osmolite via tube and will check the medication rooms for expired medications, syringes, supplies,</p>

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F 322	Continued From page 12 The tube feeding physician order, dated 10-08-12, stated "Osmolite 1.5 1/2 can QID (4 times daily) via PEG tube." The order sheet indicated that these feedings were scheduled for 8:00am, 12:00noon, 4:00pm, and 6:00pm. On 03-12-13 at 11:00am, the Syringa 2 RN Case Manager was notified that a whole can of Osmolite had been given to Resident #7 rather than 1/2 can. She did not provide any information that resolved the concern. 2. On 03-12-13 at 10:15am, the medication room on Syringa 1 was reviewed with the Syringa 1 RN Case Manager in attendance. The following were found in an upper cupboard: 1. 2 cans of Jevity 1.5 cal with an expiration date of 1-1-13. 2. 4 cans of Jevity 1.5 cal with an expiration date of 2.1-13. 3. a large container of Pivot 1.5 tube feeding solution with an expiration date of March 1, 2013. All of the above findings were shared with the administrator and DoN on 3-12-13 at 3:16pm. No further information was provided. Please see F332 for medication errors related to the care of feeding tubes.	F 322	and tube feeding cans weekly x4, bi-weekly x2, and monthly x3. Audit results will be reported to the monthly QI meeting for further monitoring and plan modification. <u>Date of Compliance</u> April 12, 2013	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332	F332 – Free of Medication Error Rates of 5% or more. <u>Resident Specific</u> LNs #7, #8, and #11 have all been re-educated for failure to administer	4/12/13

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F 332	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy review and resident record review, it was determined that the facility failed to maintain a medication error rate less than 5% when medications were combined when given through feeding tubes, iron was given with incompatible drugs, and esomeprazole was given with enteral feeding formula rather than one hour before. This affected 3 of 8 residents (#21, #22, and #23) reviewed for medication administration practices. This resulted in an error rate of 8.16% when there were 4 errors out of 49 opportunities for error. This created the potential that residents would receive less than optimum benefit from prescribed medication. Findings include:</p> <p>CMS Letter 13-02-NH, dated November 2, 2012, stated on page 2, regarding administration of medications via a feeding tube, "Failure to flush before and in between each medication administration is considered a single medication error and would be included in the calculation for medication errors exceeding 5 percent."</p> <p>1. On 03-11-13 at 11:51am, LN #7 was observed administering medication and Osmolite 1.5 to Resident #21. LN #7 entered Resident #7's room with one plastic cup containing 5cc of ferrous sulfate (iron) and a second plastic cup containing acetaminophen 500ml and esomeprazole 40mg (both in one container.) LN #7 confirmed that the two plastic cups contained these medications. LN#7 then checked the PEG tube for placement, and attached a syringe to the PEG tube. She also opened a can of Osmolite 1.5 and indicated she was also going to give a bolus tube feeding.</p>	F 332	<p>medications according to proper procedure and according to the Nursing 2012 Drug Handbook.</p> <p><u>Other Residents</u></p> <p>All resident medication orders have been reviewed and changes made to avoid combining incompatible drugs, clarifying the right times to administer medications and flushing the feeding tube before and in between each medication administration.</p> <p><u>Facility System</u></p> <p>Nursing was in-serviced on 3/25, 3/26, 3/28, 3/29, 4/2, 4/3, and 4/4/13 about following GSS procedures and physician orders to avoid combining incompatible medications, when to administer medications and flushing the feeding tube before and in between each medication administration. Tube feeding procedures have been added to the yearly LN compliance checklist.</p> <p><u>Monitor</u></p> <p>The RN care managers will audit nurse medication pass via tube weekly x4, bi-weekly x2, and monthly x3 to ensure proper procedures and physician orders are being followed. Audit results will be reported to the monthly QI meeting for further monitoring and plan</p>		

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F 332	<p>Continued From page 14</p> <p>She flushed the PEG tube with about 30cc of water. Then she poured osmolite into the syringe, then she poured in some of the ferrous sulfate, then more Osmolite, then some of the acetaminophen/esomeprazole combination, then more Osmolite. She continued to fill the syringe, alternating between the Osmolite and the two medication containers until all the medications and all the can of Osmolite had infused into the resident. Then she flushed the PEG tube with about 30cc of water. She did not give the medications separately and flush between each medication, and she mixed all the medications together in the syringe with the Osmolite.</p> <p>The facility's procedure for "Medication Administration through Tube Feeding, last revised February 2006, stated on page 2 "Do not mix medications with enteral feeding formula....If more than one medication is to be administered, give each one separately and rinse tube with five cc (ml) of warm water in between medication."</p> <p>The observation resulted in one error for mixing all the medications with the tube feeding. The "Nursing 2012 Drug Handbook on page 583 states, regarding Ferrous Sulfate "Interactions Drug-Drug....proton pump inhibitors: May decrease iron absorption. Separate doses if possible." This same resource states that esomeprazole is a proton pump inhibitor (page 523). Further, the physician's order for the esomeprazole dated 05-28-10 stated "Give 1 hour before a meal." This drug was given directly with the bolus can of Osmolite rather than one hour earlier. This was a timing error.</p> <p>2. On 03-12-13 at 7:10am, LN #8 was observed</p>	F 332	<p>modification.</p> <p><u>Date of Compliance</u></p> <p>April 12, 2013</p>		

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F 332	<p>Continued From page 15</p> <p>giving medications to Resident #23. LN #7 poured 9 medications into a medication cup, including Calcium Carbonate 500mg one tab and Ferrous Sulfate 325mg one tab, and gave it to the resident. The resident swallowed all the medications in the cup. Both drugs had current physician orders, signed 02-27-13, indicating that the medications were to be given at 8:00am daily. However, these two drugs are not compatible. The "Nursing 2012 Drug Handbook" on page 240 indicates that calcium carbonate is an antacid; on page 583, regarding ferrous sulfate, it states "Interactions Drug-drug. Antacids.....: May decrease iron absorption. Separate doses if possible."</p> <p>On 03-12-13, the pharmacist was interviewed with the Syringa 1 RN Case Manager also present. When asked about the practice of giving iron mixed in enteral feeding formula (as in example #1 above) and giving iron together with calcium carbonate, the pharmacist confirmed that both practices were known to decrease iron absorption.</p> <p>3. On 03-11-13 at 7:54am, LN #11 asked the surveyor if she wanted to observe a tube feeding. LN #11 had 3 plastic cups of liquid in hand as she entered Resident #22's room. She stated that one cup contained gabapentin, one contained plain water, and one contained three different medications, 'all her powdered meds.' She listed the three medications contained in the third cup as Sprintec, Tizanidine, and a third that sounded like Laratadine. LN#11 administered the three medications mixed together rather than giving them separately and flushing the tube between each. This counted as one error.</p>	F 332			

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F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</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:</p>	F 431	<p>F431 – Drug records, Label / Store Drugs and Biologicals</p> <p><u>Resident Specific</u></p> <p>Medications have been accurately labeled by the pharmacy for residents #24 and #25.</p> <p><u>Other Residents</u></p> <p>All resident medications have been reviewed to ensure they were labeled accurately and according to current physician order(s). Pharmacy was notified of any label changes that needed to be made.</p> <p><u>Facility System</u></p> <p>Nursing was in-serviced on 3/25, 3/26, 3/28, 3/29, 4/2, 4/3, and 4/4/13 about checking to make sure each medication is labeled accurately and according to current physician order(s). Pharmacy will now spell out “lesser than” or “greater than” and no longer be using symbols. Pharmacy will be immediately notified of any medication discrepancies and nursing will not pass that specific medication until the discrepancy is resolved.</p> <p><u>Monitor</u></p> <p>The RN care managers will audit</p>	4/12/13	

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

PRINTED: 03/25/2013
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 03/15/2013
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 431	Continued From page 17 Based on observation and staff interview, it was determined the facility failed to ensure that medications were accurately labeled. This was the case for two of 8 residents (#24 and #25) reviewed during medication pass. This created the potential that medications would be given incorrectly. Findings include: 1. On 3-12-13 at 7:35am, LN #9 was observed to give Resident #24 Fluticasone 50 mcg, one spray in each nostril. The label read "Instill 2 sprays in each nostril once daily." LN #9 commented that the label did not match the current order. The current physician order, dated 3-11-13, stated "fluticasone nasal spray 1 puff to each nostril bid (twice a day)." 2. On 3-12-13 at 9:20am, LN #10 was observed to give morning medications to Resident #25. LN #10 indicated that she had taken Resident #25's apical pulse earlier that morning and it was over 60. Resident #25 was given Metoprolol ER 25mg one tablet. The label on the Metoprolol stated "Hold if pulse > (greater than) 50." The physician order dated 03-14-10 stated "Hold if apical pulse < (less than) 50." The administrator and DoN were notified of the above findings on 3-12-13 at 3:16pm. No further information was provided.	F 431	medications weekly x4, bi-weekly x2, and monthly x3 to ensure they are labeled correctly and follow current physician order(s). Audit results will be reported to the monthly QI meeting for further monitoring and plan modification. <u>Date of Compliance</u> April 12, 2013	
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.	F 441	F441 – Infection Control, Prevent Spread, Linens <u>Resident Specific</u> The large container of Osmolite 1.2 for Resident #26 was discarded.	4/12/13

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F 441	<p>Continued From page 18</p> <p>(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, 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 that enteral feeding formula was stored so as to minimize the potential for cross-contamination.</p>	F 441	<p><u>Other Residents</u></p> <p>The specimen refrigerator was inspected to ensure nothing but specimens were stored.</p> <p><u>Facility System</u></p> <p>Nursing was in-serviced on 3/25, 3/26, 3/28, 3/29, 4/2, 4/3, and 4/4/13 about not storing anything but specimens in specimen refrigerator. Specimen refrigerator in Syringa I medication room was re-labeled to include no medications, no food, and no drinks.</p> <p><u>Monitor</u></p> <p>The RN care managers will audit specimen refrigerator weekly x4, bi-weekly x2, and monthly x3 to ensure they are storing only specimens. Audit results will be reported to the monthly QI meeting for further monitoring and plan modification.</p> <p><u>Date of Compliance</u></p> <p>April 12, 2013</p>	

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F 441	<p>Continued From page 19</p> <p>This was the case for one of four medication storage areas in the facility. This created to potential to spread infection from resident to resident. Findings include:</p> <p>On 03-12-13 at 10:15am, the medication room on Syringa 1 was reviewed with the Syringa 1 RN Case Manager in attendance. The room contained a medication refrigerator and a specimen refrigerator. Inside the specimen refrigerator was a large container of Osmolite 1.2. This container was labeled with Resident #26's name and 'opened 3-11.' The Syringa 1 RN Case Manager confirmed that the enteral feeding formula should not be stored in the specimen refrigerator.</p> <p>The administrator and DoN were informed of these findings later that day at 3:16pm. No further information was provided.</p>	F 441			

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 03/15/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - BOISE VILLAGI		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 SYCAMORE DRIVE BOISE, ID 83703		
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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the State licensure and complaint investigation survey of your facility. The surveyors conducting the survey were: Karen Marshall, MS, RD, LD Team Coordinator Monica Nielsen, QMRP, MEd Loretta Todd, RN Karla Gerleve, RN Brad Perry, BSW, LSW	C 000	<u>General Disclaimer</u> 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.	
C 393	02.120.04,b Staff Calling System at Each Bed/Room b. A staff calling system shall be installed at each patient/resident bed and in each patient/resident toilet, bath and shower room. The staff call in the toilet, bath or shower room shall be an emergency call. All calls shall register at the staff station and shall actuate a visible signal in the corridor at the patient's/resident's door. The activating mechanism within the patient's/resident's sleeping room shall be so located as to be readily accessible to the patient/resident at all times. This Rule is not met as evidenced by: Refer to F246 regarding call lights placed out of reach.	C 393	C 393 – Staff Calling System at Each Bed/Room Please refer to Plan of Correction for F246.	4/12/13

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APR 08 2013
FACILITY STANDARDS

Bureau of Facility Standards
[Signature]
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
Administrative

(X6) DATE
4/8/13

Bureau of Facility Standards

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C 445 C 445	<p>Continued From page 1</p> <p>02.120,13,c Hot Water Temps 105-120 Degrees F</p> <p>c. The temperature of hot water at plumbing fixtures used by patients/residents shall be between one hundred five degrees (105F) and one hundred twenty degrees (120F) Fahrenheit.</p> <p>This Rule is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure the temperatures of hot water used by the residents were between 105 degrees F [Fahrenheit] and 120 degrees F. This affected 1 of 5 (Room 206) resident rooms tested and 1 of 5 (Syringa I Shower Room) shower rooms tested.</p> <p>On 3/12/13 between:9:10 AM and 10:15 AM, The Director of Environmental Services was observed taking water temperatures in multiple areas of the facility. The water temperatures were as follows:</p> <p>Room 206 09:40-100 degrees F 10:05-103.1 degrees F 10:10-103 degrees F Shower Room on Syringa I Unit 10:05-104.2 degrees F</p> <p>On 3/12/13 at 3:45 PM the administrator and the DON were informed of the low water temperatures.</p> <p>On 3/14/13 at 2:30 PM the Director of Environmental Services provided a weekly Water Temperature Record for the facility. However, the record failed to show water temperatures in the shower rooms and failed to show every room in the facility had been tested on a weekly basis.</p>	C 445 C 445	<p>C 445 – Hot Water Temps</p> <p><u>Resident Specific</u></p> <p>Resident(s) residing in Room 206 were able to use hot water between 105 degrees F and 120 degrees F by using other areas of the facility. Showers for Syringa I residents were given on other units where the water was between 105 degrees F and 120 degrees F.</p> <p><u>Other Residents</u></p> <p>Not having hot water between 105 degrees F and 120 degrees F has the potential to affect all residents.</p> <p><u>Facility System</u></p> <p>The hot water on Syringa I was restored on 3/18/13 and has been set to 118 degrees. It was found that the tempering valve was stuck in one position and would not modulate. The valve was tore down and thoroughly cleaned. The valve is now functioning properly and a routine inspection / cleaning has been set in place by Environmental Services.</p> <p><u>Monitor</u></p> <p>Environmental Services will audit the water temperatures for Syringa I rooms and Shower Room weekly x4, bi-weekly x2, and monthly x3 to ensure they are between 105 degrees F and 120 degrees F. Audit results will be reported to the monthly QI meeting for further monitoring and plan modification.</p> <p><u>Date of Compliance</u></p> <p>April 12, 2013</p>	4/12/13

Bureau of Facility Standards

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C 647	02.150,01,a,iv STERILE SUPPLY STORAGE AREAS iv. Sterile supply storage areas. This Rule is not met as evidenced by: Refer to F441 regarding enteral feeding formula found in the specimen refrigerator.	C 647	C 647 – Sterile Supply Storage Areas Please refer to Plan of Correction for F441.	4/12/13
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 regarding care plan revisions not completed.	C 782	C 782 – Reviewed and Revised Please refer to Plan of Correction for F280	4/12/13
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F322 regarding staff not following tube feeding orders. Refer to F332 regarding medication errors.	C 788	C 788 – Medications, Diet, Treatment as Ordered Please refer to Plan of Correction for F322 and F332.	4/12/13
C 789	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by:	C 789	C 789 – Prevention of Decubitus Please refer to Plan of Correction for F314.	4/12/13

Bureau of Facility Standards

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C 789	Continued From page 3 Refer to F314 regarding care of pressure sores.	C 789		
C 832	02.201,02,f f. All medications shall be labeled with the original prescription legend including the name and address of the pharmacy, patient's/resident's name, physician's name, prescription number, original date and refill date, dosage unit, number of dosage units, and instructions for use and drug name. (Exception: See Unit Dose System.) This Rule is not met as evidenced by: Refer to F431.	C 832	C 832 Please refer to Plan of Correction for F431.	4/12/13



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
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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April 9, 2013

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

Provider #: 135085

Dear Mr. Davidson:

On **March 15, 2013**, a Complaint Investigation survey was conducted at Good Samaritan Society - Boise Village. Karen Marshall, R.D., Monica Nielsen, Q.M.R.P., Loretta Todd, R.N., Karla Gerleve, R.N. and Bradley Perry, L.S.W. conducted the complaint investigation. This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey.

The identified resident's closed medical record was reviewed. The resident was originally admitted to the facility on May 1, 2012. The resident was transferred to a local hospital on September 7, 2012, returned to the facility September 13, 2012, and then was discharged January 25, 2013.

The survey team reviewed eleven other residents for quality of life and quality of care issues, including but not limited to tube feeding, swallowing, grooming and specialized rehabilitation services.

Interviews were conducted with the Director of Nursing, Social Services, the Administrator and the Speech Language Pathologist.

Interviews were also conducted with the Licensed Nurse Unit Manager where the resident resided in the facility and a different Licensed Nurse who provided cares for the resident.

Brian J. Davidson, Administrator
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The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005766

ALLEGATION #1:

The complainant stated an identified resident had a decline in walking and continence since admission. The resident was not getting the amount of therapy the resident needed.

FINDINGS:

Review of the identified resident's medical record revealed the resident's attending physician ordered and the resident participated in physical therapy and occupational therapy. The resident was discharged from physical therapy because the resident's previous level of functioning was achieved. The resident was discharged from occupational therapy because goals were met.

Three other residents were reviewed for specialized rehabilitation services. The survey team did not identify concerns related to specialized rehabilitation services.

The survey team determined the facility was in compliance with federal guidelines.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated an identified resident was hospitalized for dehydration and aspiration pneumonia, possibly due to staff failing to cue properly during meals.

FINDINGS:

Review of the identified resident's medical record and interviews with facility staff revealed the following:

The resident was evaluated by a Speech Language Pathologist (SLP) on admission, May 2012. The SLP determined the resident had swallowing concerns. The resident expressed the desire to continue to eat and drink regular foods and liquids. The resident was followed and monitored by the SLP and was permitted to eat chopped foods and thin fluids under the restorative dining. In addition, the resident received occupational therapy for self-feeding from admission to July 2, 2012.

Brian J. Davidson, Administrator

April 9, 2013

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A July 19, 2012, care-planning meeting was attended by the resident, the resident's legal guardian, a representative from a local guardianship and care management company, the guardian attorney, the physical therapist, the occupational therapist, the SLP, the resident's unit manager, the facility's rehabilitation nurse and a close family member. During this care-planning meeting, the resident expressed the desire to continue to eat regular textured foods and drink thin liquids. The care planning meeting consensus was to allow the resident the foods and liquids the resident desired for the resident's quality of life. The decision was also made, in the event consuming regular textured foods and thin liquids did not meet the resident's nutritional needs or posed a threat to the resident's life and safety other nutritional interventions would be implemented. The resident agreed with the care planning meeting decisions. These care-planning decisions were coordinated with the resident's attending physician.

According to the resident's care plan and progress notes, the resident was provided with supervised, restorative dining and appropriate interventions to provide food and fluids in a form and sequence beneficial for the resident. The resident was able to feed himself using a plate guard and was provided partial to total assistance to complete meals as fatigue developed. The resident received small bites of chopped meats. Fluids were provided in between the small bites of chopped meats. The small bites of chopped meats and the fluids were not given in the same bite.

Unfortunately, the identified resident was found unresponsive and was transferred to a local hospital for evaluation. One of three documents completed by the local hospital identified the resident was dehydrated. The local hospital's Emergency Department report identified the resident was dehydrated. The local hospital's History and Physical summary and the Discharge summary did not identify the resident was dehydrated.

The resident's attending physician saw the resident for a follow-up evaluation after return from the local hospital. The physician did not identify dehydration as a concern.

The local hospital's Emergency Department report did not identify aspiration pneumonia as a diagnosis or concern. The local hospital's History and Physical identified probable aspiration pneumonia as a concern. The local hospital's Discharge Summary identified aspiration pneumonia as a discharge diagnosis.

Upon return to the facility, another care-planning meeting was held and the determination was made to implement different nutritional interventions as discussed in the care-planning meeting held in July 2012. According to the resident's medical record, the nutritional interventions were put into place, and the resident was followed by the SLP. The resident's attending physician ordered a tube feeding by way of a percutaneous endoscopic gastrostomy (PEG) tube. The physician's order also included water flushes by way of the PEG tube, and the Frazier Free Water

Brian J. Davidson, Administrator
April 9, 2013
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Protocol was implemented under the supervision of the SLP.

Although the survey team verified the resident was hospitalized for dehydration and aspiration pneumonia, it was determined the facility was in compliance with federal guidelines.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated an identified resident had a tube feeding because of swallowing problems and weight loss. The complainant felt the tube feeding was unnecessary.

FINDINGS:

The facility informed the resident of potential consequences of choices made and permitted the resident the right to make choices related to care needs. The resident was advised of the risks associated with the choices made by the resident. The facility also incorporated the resident's choices regarding treatment, care and services into the resident's care plan and daily routines all the while maintaining the resident's quality of life.

Review of the identified resident's medical record revealed the resident's attending physician ordered a tube feeding because of the resident's aspiration pneumonia. In addition, the physician ordered speech therapy to begin again working with the resident.

Review of the resident's medical record did not reveal the resident sustained a weight loss. The resident's documented weight status verified the resident did not sustain a weight loss while at the facility. In addition, the resident's attending physician addressed the resident's weight during visits and determined the resident's weight was stable.

The survey team determined the facility was in compliance with federal guidelines.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated an identified resident's fingernails and toenails were long and unkempt. The resident's hair was long and scalp and ears were full of psoriasis.

Brian J. Davidson, Administrator
April 9, 2013
Page 5 of 5

FINDINGS:

Federal guidelines provide residents the right to choose how long or short their hair will be.

The resident's attending physician ordered a medicated moisturizer for the resident's face, ears and scalp.

The resident's medical record provided evidence that nursing staff applied the moisturizer to the resident's face, ears and scalp as ordered. Nursing staff performed daily skin checks. Progress notes did not provide evidence that the resident's fingernails and toenails were long and unkempt or that the resident's scalp and ears were full of psoriasis.

During the survey process, eleven different residents were reviewed for grooming and hygiene concerns and assistance provided for activities of daily living. The survey team did not identify concerns with grooming or hygiene or assistance with activities of daily living.

The survey team determined the facility was in compliance with federal guidelines.

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,


LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj