



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  
FAX 208-364-1888

**CERTIFIED MAIL: 7012 1010 0002 0836 1598**

June 9, 2014

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

Provider #: 135085

Dear Mr. Davidson:

On **May 23, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Good Samaritan Society - Boise Village by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be 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 and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both the Form

Brian J. Davidson, Administrator  
June 9, 2014  
Page 2 of 4

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 **June 23, 2014**. Failure to submit an acceptable PoC by **June 23, 2014**, may result in the imposition of civil monetary penalties by **July 14, 2014**.

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 will you make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice does 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 have 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 (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.

Brian J. Davidson, Administrator  
June 9, 2014  
Page 3 of 4

- 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 **June 27, 2014 (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 **June 27, 2014**. A change in the seriousness of the deficiencies on **June 27, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 27, 2014** includes the following:

Denial of payment for new admissions effective **August 23, 2014**. [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 **November 23, 2014**, 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 Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **May 23, 2014** and continue until substantial

Brian J. Davidson, Administrator  
June 9, 2014  
Page 4 of 4

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 **June 22, 2014**. If your request for informal dispute resolution is received after **June 22, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,



LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor  
Long Term Care

LKK/dmj  
Enclosures

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/23/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the annual federal recertification and complaint survey of your facility.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Susan Gollobit, RN Nina Sanderson, BSW, LSW Jana Duncan, RN, MSN Noel Mathews, MSW Judy Atkinson, RN</p> <p>The survey team entered the facility on May 19, 2014 and exited on May 23, 2014.</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CNA = Certified Nurse Aide DON/DNS = Director of Nursing Services LN = Licensed Nurse LPM=Liters Per Minute MAR = Medication Administration Record MDS = Minimum Data Set assessment O2=Oxygen PRN = As Needed R/T=Related To UM=Unit Manager</p>	F 000	<p><b><u>General Disclaimer</u></b></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>	
F 157 SS=D	<p><b>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</b></p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician</p>	F 157	<p><b>F157 – Notification of Changes</b></p> <p><b><u>Resident Specific</u></b></p> <p>A late entry notation was made in the resident's record stating the physician was notified on 5/10/14 regarding resident #11's health status change.</p>	<b>6/27/14</b>

RECEIVED  
JUN 20 2014  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X6) DATE <b>6/20/14</b>
---	-------------------------------	-----------------------------

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 157	<p>Continued From page 1</p> <p>intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility did not ensure a resident's physician was informed of a significant change in the resident's status. This was true for 1 of 11 (#11) residents sampled. The deficient practice had the potential for more than minimal harm when Resident #11's physician was not notified of a change in the residents status regarding opportunities for treatment. Findings include:</p>	F 157	<p>The physician ordered for nursing to monitor the situation.</p> <p><b><u>Other Residents</u></b></p> <p>All residents have the potential to be at risk when the physician is not notified of significant health status changes. Audits of all resident significant health status changes for the past month have been completed to ensure the physician(s) were notified.</p> <p><b><u>Facility System</u></b></p> <p>In-servicing will be completed by 6/26/14 for all licensed nurses related to notifying the physician of health status changes.</p> <p><b><u>Monitor</u></b></p> <p>Starting on 6/20/14, the RN care managers will audit weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure physician notifications have occurred. Audit results will be reported to the monthly QI meeting for further monitoring and plan modification.</p> <p><b><u>Date of Compliance</u></b></p> <p>June 27, 2014</p>		

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE</b> <b>BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 157	<p>Continued From page 2</p> <p>Resident #11 was admitted to the facility on 4/20/12 and readmitted on 3/19/13 with multiple diagnoses which included generalized pain and dysthymic disorder.</p> <p>Resident #11's significant change MDS assessment dated 2/27/14, documented the resident had moderately impaired decision making skills and was independent for most ADL's including bed mobility.</p> <p>The resident's Interdisciplinary Progress Notes documented: -5/8/14 at 14:29 [2:29 PM], "Newly noted bruising on bilateral forearms. Looks to be from bumping arm on side table when eating." -5/9/14 at 10:23 AM, "No change to bruising. Remains intact and no increase in size." -5/14/14 at 14:28 [2:28 PM], "SAR [Skin at Risk Assessment]: Bruise to bilateral forearms are healing without difficulties noted. [Resident #11] states she got them from staff repositioning her at night they grab her arms. Staff educated on the proper way to reposition residents. Bruise is almost resolved and healing without problems." -5/14/14 at 14:58 [2:58 PM], "Who did you talk to/notify? [Resident #11's emergency contact]... Bruising to bil[ateral] forearms..." Note: The resident was identified to have new bruising to bilateral forearms 5/8/14 and the resident's family was not notified until 5/14/14. The physician was not notified of the resident's skin findings. See F 226 for investigations.</p> <p>On 5/21/14 at 1:25 PM, Unit Manager #3 and DNS were interviewed regarding physician notification of Resident #11's skin findings. When asked if the physician was notified of the resident's bruises the DNS said, "The resident's</p>	F 157			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 157	Continued From page 3 family was notified, I don't see the doctor notification. I will look into it."  On 5/22/14 at 4:45 PM, the DNS and the Administrator were informed of the issue. No further information was received from the facility regarding the issue.	F 157			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) <b>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</b>  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.  The results of all investigations must be reported	F 225	<b>F225 - Investigations</b>  <b><u>Resident Specific</u></b>  The injuries of unknown origin for resident's #9 and #11 were thoroughly investigated on 5/21/14 to rule out abuse and/or neglect. Late entry notations were made in each resident's record. There was no abuse and neglect.  <b><u>Other Residents</u></b>  All residents with injuries of unknown origin have the potential to be affected by this practice.  <b><u>Facility System</u></b>  In-servicing will be completed by 6/26/14 for all licensed nurses on thoroughly investigating and documenting injuries of unknown origin to rule out abuse and/or neglect. Incident report(s) will be completed to show the documentation of such	<b>6/27/14</b>	

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 4</p> <p>to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and review of the facility's Abuse Policy, it was determined the facility did not ensure all injuries of unknown origin were thoroughly investigated as potential instances of abuse and/or neglect. This was true for 2 of 5 residents (#s 9 and 11) sampled for incident investigations. The deficient practice had the potential to cause more than minimal harm if the root cause of resident incidents was not accurately identified to prevent further occurrences. Findings include:</p> <p>The facility's Abuse/Neglect policy documented:</p> <ol style="list-style-type: none"> <li>1. Screening: Have procedures to... Screen potential employees for a history of abuse, neglect or mistreating residents as defined by the applicable requirements... Back ground investigations... Reference checks</li> <li>4. Identification: Have procedures to... Identify events, such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse; and to determine the direction of the investigation...</li> <li>5. Investigation: Have procedures to... Investigate different types of incidents... Identify the staff member responsible for initial reporting, investigation of alleged violations and reporting of results to the proper authorities.</li> </ol>	F 225	<p>injuries.</p> <p><b><u>Monitor</u></b></p> <p>Starting on 6/20/14, the RN care managers will audit weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure injuries of unknown origin are thoroughly investigated. Audit results will be reported to the monthly QI meeting for further monitoring and plan modification.</p> <p><b><u>Date of Compliance</u></b></p> <p>June 27, 2014</p>		

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	<p>Continued From page 5</p> <p>The Bureau of Facility Standards Informational Letter 2005-1 documented: "A thorough investigation is critical to developing effective prevention strategies...investigators must ask probing questions to get to the root cause... essential components... include... all pertinent staff (or other witnesses) must be interviewed and the results of the interview documented in some form... in cases of injury of unknown source, all staff having possible contact with the resident over the 24 hour period prior to the injury discovery...in cases of unwitnessed incidents, the facility needs to determine when the resident was last observed by staff and what the resident was doing at the time... the facility must determine whether specific care plan approaches intended to prevent incidents... were being implemented as planned."</p> <p>1. Resident #11 was admitted to the facility on 4/20/12 and readmitted on 3/19/13 with multiple diagnoses including generalized pain and dysthymic disorder.</p> <p>Resident #11's significant change MDS assessment dated 2/27/14, documented the resident had moderately impaired decision making skills and was independent for most ADL's.</p> <p>The resident's Interdisciplinary Progress Notes documented: -5/8/14 at 14:29 [2:29 PM], "Newly noted bruising on bilateral forearms. Looks to be from bumping arm on side table when eating." -5/9/14 at 10:23 AM, "No change to bruising. Remains intact and no increase in size." -5/14/14 at 14:28 [2:28 PM], "SAR[Skin at risk</p>	F 225		

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE</b> <b>BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 6</p> <p>assessment]: Bruise to bilateral forearms are healing without difficulties noted. [Resident #11] states she got them from staff repositioning her at night they grab her arms. Staff educated on the proper way to reposition residents. Bruise is almost resolved and healing without problems." -5/14/14 at 14:58 [2:58 PM], "Who did you talk to/notify? [Resident's emergency contact]... Bruising to bil[ateral] forearms..."</p> <p>Note: No incident report was found for Resident #11 during this time period. Additionally, no further questioning of the resident or staff was documented. It was not clear how abuse had been ruled out, given the lack of statements from staff leading up to the discovery of the bruises, and the lack of documentation regarding the specific number, appearance, and location of the bruising. Additionally, there was no documented evidence of changes to the resident's care plan.</p> <p>On 5/21/14 at 1:25 PM, the DNS, UM #3 and the Administrator were interviewed regarding resident #11. When asked how the bruising initially documented on 5/8/14 was determined to be from positioning and the side table, the UM said, "She probably just assumed. I don't know what she asked the resident. When I went in to do a follow up assessment she said that when they pull her up at night staff caused the bruising. They pull her up by the forearms. We inserviced the staff and went over the proper way to reposition the residents." When asked what the bruising looked like, the UM said, "It did not look like fingerprint bruising. Just a spot on each forearm. When I looked and put my hand on her arm, the bruises lined up with the thumb." When asked if the facility did an incident report or investigated the new bruising she said, "There is not an incident</p>	F 225			

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE</b> <b>BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 7 .</p> <p>report about it." When the administrator was asked how the facility ruled out abuse, he said, "We don't just rule it out right there and then. It's a gray area. We rely on the professional assessments of the nurse. We look into things like this at the QM [quality monitoring] meetings and skin at risk (SAR) meetings. We have these meetings every Thursday. The UM then investigates and brings the information to SAR meeting for futher discussion and intervention."</p> <p>2. Resident #9 was admitted to the facility 8/17/14 with multiple diagnoses including cerebral palsy.</p> <p>The resident's most recent quarterly MDS assessment dated 3/5/14, documented the resident: *Was unable to complete BIMS interview to assess cognition; and *Was totally dependent on 1-2 staff members for bed mobility, transfers, locomotion, dressing, personal hygiene and bathing.</p> <p>Resident #9's care plan for ADL's, with a focus of "[Resident #9] has an ADL self care performance deficit [related to] [cerebral palsy], developmental delay, [history of] left hip disarticulation, contractures, spastic quadriparesis, potential [sic] for falls [evidenced by] [history of] spontaneous pathological hip [fracture], advanced osteoporosis," was initiated 12/18/13, and documented goals "[Resident #9] will have her needs met by staff through the review date." Interventions included all cares as total assistance.</p> <p>The resident's interdisciplinary Progress Notes (IDPN) and Fax Communication to Physician (Fax) documented:</p>	F 225			

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 225	<p>Continued From page 8</p> <p>-4/30/14 at 21:13 [9:13 PM], IDPN: "Writer was notified by CNA that [Resident #9] vaginal area appeared swollen. [Resident #9] seemed upset and in pain. Routine pain medications were given and [resident #9] has been quiet since. Area does appear swollen. Will continue to monitor..."</p> <p>-5/1/14 at 10:34 AM, IDPN: "[Resident #9] is experiencing pain, she is in her menses cycle and her left labia is swollen and fluid engorged to approximately 1.5 cm x 4 cm. [Resident's Physician] has been notified family has been notified. Grandmother was present."</p> <p>-5/1/14 at 20:37 [8:37 PM], IDPN: "...Area to labia continues to be swollen. [Resident #9] was crying out and quieted down after receiving her routine medications."</p> <p>-5/1/14 (untimed) Fax: "Concern: [Resident #9] is having her menses and left labia is swollen and engorged fluid size is approx 4 cm x 1.5 cm x 2 cm." Physician returned comments documented "Monitor until menses completed." Received 5/1/14 at 18:30 [6:30 PM].</p> <p>-5/2/14 at 9:04 AM, IDPN: "[Resident #9]'s labia minor protrudes past labia major [due to] gross engorgement of tissue and according to staff member labia major and labia minor is more swollen than yesterday. Labia is deep red in color, warm, and tender to touch. [Resident #9]'s face is flushed and warm. Sclera is reddened from crying off and on with discomfort. No drainage noted from area or lesion observed. [Resident #9's physician] advised via fax..."</p> <p>-5/2/14 (untimed) Fax: "Concern: No change in [Resident #9's] labia which is grossly inflamed swollen/warm and tender to touch. On NOC[night shift] had temp... Face is flushed and warm to touch. Eyes are (sclera) red from crying. Labia inner lip protrudes from labia major according to staff labia major and labia minor more swollen</p>	F 225		
-------	--	-------	--	--

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE</b> <b>BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	Continued From page 9 from 5/1/14." The physician returned comments documented, "Start Augmentin 875mg [twice daily] per ft[sic] [for] 10 days," received 5/2/14 at 12:55 PM. Note: There was no documentation regarding an investigation into the cause of the resident's injury, the physician had not assessed the resident, and the Augmentin was started 5/2/14 without a diagnosis.  On 5/21/14 at 12:45 PM, the DON and UM #2 were interviewed by the surveyors regarding Resident #9's findings. The UM #2 said, "Her labia on the left side was 3-4 times it's normal size. There was no puss, just swelling. We took measurements and notified the MD. It seemed painful and she was having her menses. We assessed her with her family member in the room. We sent more info to the MD and got antibiotic orders. We described everything to the MD, this was his recommendation." When asked what the diagnosis was associated with the findings and the antibiotics the DNS said, "He didn't write a diagnosis. He sometimes forgets; We will get that from him as soon as possible." The DNS said, "It looked like a gland got plugged." When the UM and DNS were asked how they came to the conclusion that her injury was caused by an infection and if there was an investigation or incident and accident report the DNS said, "No." UM #2 said, "We notified the MD, he ordered antibiotics and no labs, the swelling went down with the antibiotics." When the UM was asked how they ruled out abuse in the resident who is high risk for abuse, UM #2 said, "Well, she has only female caregiver, no male caregivers go into her room." The DNS said, "There was no evidence of trauma, no bruising," When asked if this was documented anywhere	F 225			

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	<p>Continued From page 10</p> <p>she said, "No." The UM said, "We chart by exception. We wouldn't document that if we didn't see it. We should have written no evidence of trauma. If I thought there was some potential, we would have have been all over it. If there was any type of abuse she would have been able to communicate that with her family member." When asked if the facility spoke with the family about concerns or abnormal behavior from the resident the UM said, "I didn't ask the family member those questions. She did not show any signs of concern." When asked how the resident would show signs that would indicate abuse, the UM #2 said, "Her family member can determine pain versus fear. She can isolate things down to some respect. But the family member wasn't concerned about abuse and we didn't think of it either." When asked if the physician had evaluated the resident yet, UM #2 said, "He comes in next Wednesday."</p> <p>On 5/21/14 at 1:40 PM, Resident #9's family member was interviewed by the surveyor. When asked if the resident had ever had an injury like this before she said, "I don't remember this ever happening before. I don't know what caused it." When asked if the facility had identified a cause she said, "I don't know what caused it. Perhaps regular diaper changing, or from not being changed often enough." When asked if she had any concerns regarding the resident's injury she said, "Nothing was unusual besides the pain. As long as she was being still it didn't seem to bother her much."</p> <p>On 5/21/14 at approximately 3:00 PM, the following document was received from the facility. "To whom it may concern: [Resident #9]... was recently diagnosed with vulvitis which is usually</p>	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	Continued From page 11 caused by an infected gland on one side of the vulva. It was descried by the nursing staff as one sided, swollen, red and fluctuant consistent with an infection. There were no other obvious signs of trauma to the area, such as abrasions or lacerations. On the basis of the description the diagnosis of vulvitis was made and she was treated with antibiotics in an appropriate fashion. There have been no subsequent issues noted." The document was signed by Resident #9's physician.	F 225			
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on review of the facility's abuse policies and procedures, staff personnel files, and staff interviews, it was determined the facility failed to operationalize its abuse policies and procedures when the facility failed to obtain background checks for 4 of 5 employees reviewed for background checks and failed to obtain reference checks for 3 of 5 employees reviewed for reference check (Staff A, B,C, D). In addition, the facility did not verify abuse history with the State Nurse Aide Registry for 1 of 2 CNA's hired. This practice created the potential to place residents at risk for and subject to abuse, neglect, or misappropriation of property. Findings included:	F 226	<b>F226 – Abuse &amp; Neglect</b>  <b><u>Resident Specific</u></b>  The State criminal history checks were completed for Staff A, C, and D on 5/22/14. Staff B's criminal history check was completed on 3/1/14. Reference checks had been completed for Staff A, C, and D on 5/22/14. The State Nurse Aide Registry Check for Staff C was completed on 5/22/14.  <b><u>Other Residents</u></b>  All new hires have the potential to be affected by this practice. A complete audit of hired and terminated employees over the past four months was completed to ensure State Criminal History Checks, Reference Checks, and required Licensure Verification Checks had been completed.	<b>6/27/14</b>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	<p>Continued From page 12</p> <p>The facility abuse policy and procedures documented the following: "1. Screening (483.13(c)(1)(ii)(A)&amp;(B): Have procedures to: Screen potential employees for a history of abuse, neglect or mistreating residents as defined by the applicable requirements at 483.13(c)(1)(ii)(A) and (B). This includes attempting to obtain information from previous employers and/or current employers, and checking with the appropriate licensing boards and registries." Note: This is the exact language found in the interpretive guidance at F226.</p> <p>On 5/22/14 at 1:15 PM, five employee personnel files were reviewed with the Human Resources Coordinator (HRC) for the state's criminal history check verification. Staff A, C, and D who were hired on 4/24/14, 4/18/14, and 4/7/14 respectively, did not have a copy of the Notice of Clearance letter or background check verification in their personnel files within 21 days of hire. Staff B who was hired on 1/23/14, had a copy of a Notice of Clearance letter in his personnel file, however, it was dated 3/1/14, which was more than 21 days after the employee's hire date.</p> <p>Staff A, C, and D also did not have reference checks in their personnel files and the HRC said she was in the process of obtaining reference checks for the employees in question. The HRC said she was just hired two weeks ago and the facility had not had an HRC for about two months prior to her hire.</p> <p>Two employee personnel files were reviewed for the State Nurse Aide Registry check. Staff C, who was employed as a CNA, did not have a copy of the verification check within 21 days of hire. Note:</p>	F 226	<p><b><u>Facility System</u></b></p> <p>Human Resources Coordinator (HRC) will conduct reference checks prior to conditional offer. The HRC will check and print for criminal history checks and required licensure verifications upon conditional offer approval. Once new hires have completed first day of general orientation, the HRC will audit the new hire folders to ensure reference checks, criminal history checks, and required licensure verifications are present. The HRC will develop in outlook a reminder to check and print out license verifications as they come due.</p> <p><b><u>Monitor</u></b></p> <p>Starting on 6/20/14, the HRC will audit new employee files weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure the files have reference checks, criminal history checks, and required licensure verifications. Audit results will be reported to the monthly QI meeting for further monitoring and plan modification.</p> <p><b><u>Date of Compliance</u></b></p> <p>June 27, 2014</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	Continued From page 13 Background and Nurse Aide Registry checks printed and dated 5/22/14, did not document any abuse findings.  On 5/22/14 at 2:25 PM, the HRC told the surveyor she could not find any other documentation in the personnel files to show the issues identified could be resolved and stated, "Going forward, we will keep them [background, reference, and Nurse Aide Registry checks] in the files."  On 5/22/14 at 4:45 PM, the Administrator and DNS were informed of the issues. No further documentation was provided by the facility.	F 226			
F 246 SS=D	<b>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</b>  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure a resident had access to her call light. This was true for 1 of 16 residents (Resident #1) sampled for call light accessibility. The deficient practice had the potential to cause more than minimal harm when the resident was unable to alert staff to her needs. Findings included:  Resident #1 was admitted to the facility on	F 246	<b>F246 – Reasonable Accommodation of Needs / Preferences</b>  <b><u>Resident Specific</u></b>  The call light for resident #1 was immediately placed in a location accessible to the resident. Resident #1 was re-assessed for call light accessibility and the resident's care plan updated to reflect guidance to staff.  <b><u>Other Residents</u></b>  All residents have the potential to be at risk when call lights are not accessible. A complete audit of all resident call lights was done to ensure each call light was accessible.	<b>6/27/14</b>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 05/23/2014
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	Continued From page 14 4/22/13 with multiple diagnoses which included CVA (cerebral vascular accident/stroke) with expressive aphasia and vascular dementia.  Resident #1's most recent annual MDS assessment, dated 4/1/14, coded: *Severely impaired decision making skills; and *Extensive assistance of 2 persons for bed mobility and transfers.  On 5/20/14 at 8:30 AM, Resident #1 was observed lying in her bed, positioned on her left side. The resident's body was positioned on the lower 2/3 of the bed, with two pillows above her head in the bed. Her call light was clipped to the upper right hand corner of one of her pillows, above and to the right (behind) of her head approximately 6 inches in each direction. The resident was awake. The surveyor asked the resident how she would alert the nurse if she needed help. The resident began to grope at the blankets around her torso, then stated, "I don't know." When cued to reach her call light, the resident could not find it. Between 8:30 and 9:45 AM, observations were made of the resident every 5-10 minutes. The call light remained out of her reach during that time. At 10:15 AM, the resident was observed sitting in her wheelchair in her room, receiving medications from the nurse.  On 5/2/14 at 4:00 PM the Administrator and DNS were informed of the surveyor's observations. The DNS stated the call light should have been within the resident's reach. The facility offered no further information.	F 246	<b><u>Facility System</u></b>  In-servicing will be completed by 6/26/14 for all nursing staff related to resident needs assessment for call light accessibility.  <b><u>Monitor</u></b>  Starting on 6/20/14, the RN care managers will audit weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure the proper positioning of call lights. Audit results will be reported to the monthly QI meeting for further monitoring and plan modification.  <b><u>Date of Compliance</u></b>  June 27, 2014		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280	<b>F280 – Right to participate in Care Plan/Revising the Care Plan</b>	6/27/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	<p>Continued From page 15</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the comprehensive care plan was reviewed and revised to reflect current resident needs for 2 of 2 residents (#s 7 and 9) sampled with Baclofen pumps. The facility failed to care plan how to maintain the Baclofen pump. This had the potential for harm if the residents did not receive appropriate care due to lack of direction in the care plan. Findings included:</p> <p>1. Resident #7 was admitted to the facility on 1/6/96 with multiple diagnoses including unspecified quadriplegia and muscle spasms. The resident's recapitulation Physician's Orders</p>	F 280	<p><b><u>Resident Specific</u></b></p> <p>Resident #7 and #9's care plans were revised on 6/13/14 to address the Baclofen pump medication rate, maintenance schedule, who is responsible for maintenance of pump, and the location of the pump on the residents body.</p> <p><b><u>Other Residents</u></b></p> <p>All residents utilizing Baclofen pumps have the potential to be affected by this practice. RN care managers audited the care plans of all residents on Baclofen pumps to ensure they are current and comprehensive.</p> <p><b><u>Facility System</u></b></p> <p>Nursing will be in-serviced by 6/26/14 regarding the Baclofen pump medication rate, maintenance schedule, who is responsible for maintenance of pump, and the location of the pump on the residents body and review of care plans to ensure they are current and comprehensive for each resident.</p> <p><b><u>Monitor</u></b></p> <p>Starting on 6/20/14, the RN care managers will audit Baclofen pump care plans weekly x 4, bi-weekly x 4, and</p>	

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 05/23/2014
--	--	--	---

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 280	<p>Continued From page 16 dated 5/20/14 documented, "Baclofen pump, new 8/27/12," with an order date of 5/9/13. Note: The order did not document the medication rate, maintenance schedule, who is responsible for maintenance of pump, or location of the pump on the resident's body.</p> <p>The resident's Care Plan dated 12/18/13, documented: *Focus-"[Resident #7] has a potential for alteration in comfort [related to] contractures, spasticity, neurogenic bowel and bladder," revised on 5/20/14. *Goals-"[Resident #7] will have effective pain management through the review date." *Interventions-"Report to Nurse any change in usual activity attendance patterns or refusal to attend activities related to [signs or symptoms] or [complaint of pain] or discomfort, Observe, record, report any [signs or symptoms of non-verbal pain, non-pharmacological interventions: reposition, warm blanket." Note: Resident #7's Care Plan did not have the Baclofen pump documented. On 5/20/14 at 3:30 PM, The surveyor asked the RN UM # 9 if she had a policy reflecting how to manage the Baclofen pump. The UM stated, "I'm not sure, I would have to look." The surveyor asked what staff does if the pump fails. RN UM #9 stated, "We contact his physician." The surveyor asked what she would do if the physician was not available. RN UM #9 stated, "They have an answering service and if that doesn't work we take him to the emergency room." The surveyor asked how the staff knows what to do. The RN UM #9 stated, "They just do. If his pain pump stops working he has visible pain and sometimes he could have seizures." On 5/22/14 at 4:45 PM, the Administrator and</p>	F 280	<p>then monthly x 3 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><b><u>Date of Compliance</u></b>  June 27, 2014</p>	
-------	--	-------	---	--

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 05/23/2014
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)	
F 280	<p>Continued From page 17</p> <p>DNS were informed of the concerns. No further information was received from the facility.</p> <p>2. Resident #9 was admitted to the facility 8/17/14 with multiple diagnoses which included cerebral palsy, quadriparesis and convulsions.</p> <p>The resident's recapitulation Physician's Orders dated 5/20/14 documented, "Baclofen pump (placed in 2010)," with the order date of 8/9/12. Note: The order did not document the medication rate, maintenance schedule, who is responsible for maintenance of pump, or location of the pump on the resident's body.</p> <p>On 10/19/13, the resident's Physician Progress Note documented, "... followed by [Resident #9 secondary physician] for Baclofen pump as well as neurology..." Note: The physician did not document the rate or maintenance of the Baclofen pump on this encounter or visits on 2/24/14, 12/6/13 or 10/19/13.</p> <p>On 4/25/14, Resident #9's Physician Progress Note documented, "Abdomen... Baclofen pump is palpable."</p> <p>The resident's care plan included a focus area dated 12/17/13, and revised on 5/2/14 titled, "[Resident #9] has chronic pain [related to] [history of] menses pain, ear aches, spinal fusion with Harrington rod. Left labia swollen and painful." Goals were documented, "[Resident #9] will exhibit improved tolerance to ear discomfort and resolution of pain with interventions, initiated on 4/14/14; [Resident #9] will display a decrease in behaviors of inadequate pain control, restlessness, crying out, moaning by the review date, initiated 12/17/13; and [Resident #9] will not</p>	F 280		

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE</b> <b>BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	Continued From page 18 have an interruption in normal activities due to pain through the review date, initiated 12/18/13." Interventions included, "Non-pharmalogical interventions 1:1, warm blanket, repositioning, chocolate syrup, ear, nose throat specialist to consult on ear discomfort and cerumen buildup, initiated 12/17/13." Note: The resident's Baclofen pump was not mentioned in the care plan.  On 5/21/14 at 3:45 PM, UM #2 was interviewed regarding the Baclofen pump. When asked what staff are expected to do when the pump alarms or malfunctions the UM said, "We get a hold of the doctor." When asked where the manual for the pump was stored, the UM said, "I'll look for that. I'm not sure where it is kept."  On 5/22/14 at 8:45, UM #2 delivered the Baclofen pump manual to the surveyors. When asked where it was found he said, "It wasn't on the unit. I called the place that supplies the doctor, they did not answer the phone. Then I went online to their website and got on the phone with the doctor's nurse and they cleared it up. They verified which pump the resident has and I printed it from the website. The doctor who manages her pump said that they do not give that information pamphlet to the units like this. We do have 24 hour access to the doctor who manages her pump. He is reliable to answer his phone or at least get back to the staff. I printed off 5 pump packets and each unit has one now."  On 5/22/14 at 4:45 PM, the DNS and Administrator were informed of the concerns, no further information was received from the facility.	F 280			
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/23/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309 SS=D	<p>Continued From page 19 <b>HIGHEST WELL BEING</b></p> <p>Each resident must receive and the facility must provide the 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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents received the necessary care and services to attain or maintain their highest practicable well-being. This was true for 2 of 2 residents (#s 7 and 9) sampled with Baclofen pumps. The facility failed to have policy and procedures for their care and maintenance as well as instructions for staff if the pump malfunctioned. This practice had the potential to cause more than minimal harm if residents did not receive the appropriate care and/or services. Findings included:</p> <p>1. Resident #9 was admitted to the facility 8/17/14 with multiple diagnoses including cerebral palsy, quadriplegia and convulsions.</p> <p>The resident's recapitulation Physician's Orders dated 5/20/14 documented, "Baclofen pump (placed in 2010), with the order date of 8/9/12." Note: The order did not document the medication rate, maintenance schedule, an identified person or location that maintained the pump or location of the pump on the resident's body.</p>	F 309	<p><b>F309 – Provide Care &amp; Services for Highest Well Being</b></p> <p><u><b>Resident Specific</b></u></p> <p>Instruction manuals for Baclofen pumps covering care, maintenance, and instructions for staff if the pump malfunctions are now available to ensure resident #7 and #9 receive the necessary care and services to attain or maintain their highest well-being.</p> <p><u><b>Other Residents</b></u></p> <p>All residents using Baclofen pumps have the potential to be affected by this practice. Residents utilizing Baclofen pumps have had care plans reviewed and are in compliance with new practice.</p> <p><u><b>Facility System</b></u></p> <p>Nursing will be in-serviced by 6/26/14 regarding the instruction manual for Baclofen pumps to include the care, maintenance and instructions for staff if the pump malfunctions. The instruction manuals will be located at each Nurse's station.</p> <p><u><b>Monitor</b></u></p> <p>Starting on 6/20/14, the RN care</p>	<b>6/27/14</b>

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE</b> <b>BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 20</p> <p>On 10/19/13, the resident's Physician Progress Note documented, "... followed by [Resident #9 secondary physician] for Baclofen pump as well as neurology..."</p> <p>Note: The physician did not document the rate or maintenance of the Baclofen pump on this encounter or visits on 2/24/14, 12/6/13 or 10/19/13.</p> <p>On 4/25/14, Resident #9's Physician Progress Note documented, "Abdomen... Baclofen pump is palpable."</p> <p>The resident's Baclofen pump was not mentioned in the care plan.</p> <p>On 5/21/14 at 3:45 PM, UM #2 was interviewed regarding the Baclofen pump. When asked what staff are expected to do if the pump alarms or malfunctions the UM said, "We get a hold of the doctor." When asked where the manual for the pump was stored, the UM said, "I'll look for that. I'm not sure where it is kept."</p> <p>On 5/22/14 at 8:45, UM #2 delivered the Baclofen pump manual to the surveyors. When asked where it was found he said, "It wasn't on the unit. I called the place that supplies the doctor, they did not answer the phone. Then I went online to their website and got on the phone with the doctor's nurse and they cleared it up. They verified which pump the resident has and I printed it from the website. The doctor who manages her pump said that they do not give that information pamphlet to the units like this. We do have 24 hour access to the doctor who manages her pump. He is reliable to answer his phone or at least get back to the staff. I printed off 5 pump packets and each unit has one now."</p>	F 309	<p>managers will audit residents using Baclofen pumps and nursing staff to ensure nursing staff are aware of change to practice and instruction manuals are still accessible and in place at Nursing stations weekly x 4, bi-weekly x 4, and then monthly x 3. Audit results will be reported to the monthly QI meeting for further monitoring and plan modification.</p> <p><b><u>Date of Compliance</u></b></p> <p>June 27, 2014</p>	

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE</b> <b>BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 21</p> <p>On 5/22/14 at 4:45 PM, the Administrator and DNS were informed of the concern. No further information was provided by the facility.</p> <p>2. Resident #7 was admitted to the facility on 1/6/96 with multiple diagnoses including unspecified quadriplegia and muscle spasms. The resident's recapitulation Physician's Orders dated 5/20/14 documented, "Baclofen pump, new 8/27/12," with an order date of 5/9/13." Note: The order did not document the medication rate, maintenance schedule, who is responsible for maintenance of pump, or location of the pump on the resident's body.</p> <p>The resident's Care Plan dated 12/18/13, documented: *Focus-"[Resident #7] has a potential for alteration in comfort [related to] contractures, spasticity, neurogenic bowel and bladder," revised on 5/20/14. *Goals-"[Resident #7] will have effective pain management through the review date." *Interventions-"Report to Nurse any change in usual activity attendance patterns or refusal to attend activities related to [signs or symptoms] or [complaint of pain] or discomfort, Observe, record, report any [signs or symptoms of non-verbal pain, non-pharmacological interventions: reposition, warm blanket." Note: Resident #7's Care Plan did not have the Baclofen pump documented. On 5/20/14 at 3:30 PM, The RN UM #9 If she had a policy reflecting how to manage the Baclofen pump. The RN UM #9 stated, "I'm not sure, I would have to look."The surveyor asked what staff does if the pump fails. UM #9 stated, "We contact his physician." The surveyor asked what she would do if the physician was not available.</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE</b> <b>BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 22 RN UM #9 stated, "They have an answering service and if that doesn't work we take him to the emergency room." The surveyor asked how the staff knows what to do. The UM #9 stated, "They just do. If his pain pump stops working he has visible pain and sometimes he could have seizures." The surveyor asked the UM #9 if she had a policy reflecting how to manage the Baclofen pump.	F 309			
F 327 SS=D	On 5/22/14 at 4:45 PM, the Administrator and DNS were informed of the concerns. No further information was received fro the facility. <b>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</b>  The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility did not ensure a resident had access to drinking water. This was true for 1 of 11 residents (Resident #1) sampled for accessibility to fluids. The deficient practice had the potential to cause more than minimal harm if the resident became dehydrated. Findings included:  Resident #1 was admitted to the facility on 4/22/13 with multiple diagnoses which included CVA with expressive aphasia and vascular dementia.  Resident #1's most recent annual MDS	F 327	<b>F327 – Sufficient Fluid to Maintain Hydration</b>  <b><u>Resident Specific</u></b>  Nursing staff immediately ensured Resident #1 had access to drinking water. Resident #1 was re-assessed for drinking water accessibility and the resident's care plan updated to reflect guidance to staff.  <b><u>Other Residents</u></b>  All residents have the potential to be affected by staff not ensuring accessible drinking water.  <b><u>Facility System</u></b>  The Nursing staff will be in-serviced by 6/26/14 on resident specific needs and	<b>6/27/14</b>	

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 327	Continued From page 23 assessment, dated 4/1/14, coded: *Severely impaired decision making skills; *Extensive assistance of 1 person for eating; and *Extensive assistance of 2 persons for bed mobility and transfers.  On 5/20/14 at 8:30 AM, Resident #1 was observed lying in her bed, positioned on her left side. The resident's body was positioned on the lower 2/3 of the bed. Her nightstand was to the left side of her bed, approximately 1 foot from the bed. Her water pitcher was visible on the back left-hand corner of the nightstand, so that the resident would have had to reach approximately 2 feet to her left and 1 foot behind her head to access the pitcher. The resident was awake. When asked if she could reach her water, the resident looked around the room immediately to each side and in front of her, but did not demonstrate awareness of the location of her water pitcher. Observations were made of the resident every 5-10 minutes until 9:45 AM, with no change in her location nor the location of her water pitcher. At 10:15 AM, the resident was observed in her wheelchair in her room, receiving medications from the nurse.  On 5/20/14 at 4:00 PM, the Administrator and DNS were informed of the surveyor's observations. The DNS stated the resident's water should have been in reach. The facility offered no further information.	F 327	assessment to ensure drinking water is accessible to residents.  <b><u>Monitor</u></b>  Starting on 6/20/14, the RN care managers will audit weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure drinking water is accessible to residents. Audit results will be reported to the monthly QI meeting for further monitoring and plan modification.  <b><u>Date of Compliance</u></b>  June 27, 2014		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services:	F 328	<b>F328 – Treatment/Care for Special Needs</b>  <b><u>Resident Specific</u></b>	<b>6/27/14</b>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 05/23/2014
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 328	<p>Continued From page 24</p> <p>Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to monitor residents who used oxygen. This was true for 1 of 1 resident sampled for oxygen use (Resident #5). This deficient practice created the potential for harm should a resident remove their nasal cannula, and did not receive oxygen therapy as ordered by the physician. Findings included:</p> <p>Resident #5 was admitted to the facility on 5/6/14 with multiple diagnoses including vascular dementia and shortness of breath (SOB).</p> <p>On 5/6/14, Resident #5's Physicians orders instructed the facility to have "O2 LPM nasal cannula, continuous."</p> <p>The Care Plan for Resident #5, dated on 5/16/14, documented: *Focus-"[Resident # 5] has an ADL self care performance deficit R/T (related to) vascular dementia...SOB..." *Goals-"[Resident #5's] ADL's will improve in bed mobility, transfers, eating, dressing, toilet use and personal hygiene by the review date." *Interventions-"Bathing: EA (extensive assist) x2,</p>	F 328	<p>Nursing staff immediately ensured Resident #5 had her nasal cannula properly placed. Consistent assignment staff was in-serviced to ensure consistency of oxygen use by resident and interventions if resident refused. Resident was re-assessed for oxygen and nasal cannula use and the care plan updated to reflect guidance to staff.</p> <p><b><u>Other Residents</u></b></p> <p>All residents using oxygen and have nasal cannulas have the potential to be affected by the practice.</p> <p><b><u>Facility System</u></b></p> <p>Caregivers #11 and #10 were re-educated on 5/21/14 about taking care of all residents using oxygen nasal cannulas and to ensure they are properly placed. All nursing staff will be in-serviced by 6/26/14 on assessment of resident's needs in use of oxygen and ensuring proper placement of oxygen nasal cannulas, including interventions to use when resident is resistive or refuses.</p> <p><b><u>Monitor</u></b></p> <p>Starting on 6/20/14, the RN care managers will audit residents receiving oxygen to ensure that nasal cannulas are</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	<p>Continued From page 25</p> <p>bed mobility: EAx2 to reposition and turn in bed, dressing: EAx1 to dress, eating: EAx1 for meals, clothing protector; family request..."</p> <p>On 5/19/14 at 11:25 AM, the surveyor observed Resident # 5 sitting in a recliner in her room with her nasal cannula was on the floor next to her chair. An oxygen concentrator was located next to the resident's recliner and was set at 2 LPM. Resident stated, "I brought that from home."</p> <p>On 5/19/14 at 12:50 PM, the surveyor observed Resident # 5 sitting in a recliner in her room. Her nasal cannula was on her forehead. The surveyor informed CNA # 11 and requested assistance for the resident. CNA #11 stated, "That's not my area," and sent the surveyor to find staff assigned to that area. The surveyor informed CNA #10 about the resident's nasal cannula and was told, "The resident often removes her oxygen. We check on her frequently."</p> <p>Note: The resident's care plan did not have any documentation regarding oxygen use and/or how the facility addressed the resident taking her nasal cannula off.</p> <p>On 5/19/14 at 12:53 PM, a surveyor observed CNA's #11 response to the above said request. The surveyor approached CNA #11 and asked her to clarify how she would notify when a resident is in respiratory distress. CNA #11 told the surveyor she, "Would have to go to another nurses station to report the issue." The surveyor asked CNA #11, "If I asked your DNS would she say not assist that resident due to not working on that hall." CNA #11 stated, "I should have helped. No, she would not say it was okay."</p> <p>On 5/21/14 at 1:20 PM, the surveyor interviewed</p>	F 328	<p>properly placed and that interventions are attempted if resident is resistant or refuses nasal cannula weekly x 4, bi-weekly x 4, and then monthly x 3. Audit results will be reported to the monthly QI meeting for further monitoring and plan modification.</p> <p><b><u>Date of Compliance</u></b></p> <p>June 27, 2014</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE</b> <b>BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 328	Continued From page 26 UM #5 and asked, "What would you expect staff to do if a visitor observed a resident in distress or a resident's nasal cannula has fallen to the floor. UM #5 stated, "We would replace the nasal cannula. The CNA's are trained to put the nasal cannula on and get a nurse to check O2 oxygen sats (saturation levels), check color, talk with the resident, document, and notify if there are any changes."  On 5/23/14 at 8:30 AM, the Administrator and DNS were informed of the oxygen issues. However, no further information or documentation was provided.	F 328			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	<b>F329 – Unnecessary Drugs</b>  <b><u>Resident Specific</u></b>  Resident #14 and the resident representative were informed on 6/18/14 of the Black Box warning for Seroquel use. Behavioral interventions, treatment for possible depression, other medications tried, other potential causes ruled out, less restrictive interventions considered, and how the resident's behavior poses a risk to self or others have all been addressed and documented for Resident #14.  Resident #4 has since expired on 6/15/14.  Resident #11 behavioral symptoms related to anxiety are being monitored	6/27/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE</b> <b>BOISE, ID 83703</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 27  This REQUIREMENT is not met as evidenced by: Based on observation, policy review, record review, and staff interviews it was determined the facility failed to ensure residents did not receive unnecessary medications. This was true for 3 of 13 sampled residents (Resident #'s 4, 11, and 14). *Residents and/or resident's representative were not provided the information on the Black Box warning for Seroquel (Quetiapine); *Residents were given antianxiety and/or antipsychotic medications without adequate monitoring; *Nonpharmacological interventions or indications for use were not documented; *Care plans did not reflect the use of medication. The deficient practice had the potential for more than minimal harm if residents experienced adverse effects from medications without clear indication for continued use. Findings include:  The facility's Psychopharmacological Medications and Sedative/Hypnotics Procedure issued 2/13 and revised 9/13, documented: "Non-Emergency Administration...If the physician prescribes an antipsychotic for the resident, a registered nurse must complete the Initial Antipsychotic Medication Assessment and the Abnormal Involuntary Movement Scale."  1. Resident #14 was admitted to the facility on 8/6/13 with multiple diagnosis including dementia without behavioral disturbance and hallucinations.	F 329	and documented. Interventions have been care planned to address anxiety.  <b><u>Other Residents</u></b>  All residents receiving medications with Black Box warnings, anti-anxiety and/or anti-psychotic medications without adequate monitoring, non-documented use of non-pharmacological interventions and care plans that do not reflect the use of the above medications have the potential to be affected by this practice.  <b><u>Facility System</u></b>  RN Care Managers will ensure the facility pharmacist informs the resident and/or resident representative of the Black Box warning.  The Nursing and Social Service staff will be in-serviced by 6/26/14 regarding Black Box Warnings. The in-service will also address anti-anxiety and/or anti-psychotic medications without adequate monitoring and expectation of use and documentation of non-pharmacological interventions, expectations for timely AIMS assessments being completed, behavioral symptoms being monitored/documented, that interventions are put into place,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 28</p> <p>The Resident's #14 quarterly MDS assessment dated 4/16/14, documented: *BIMS score of 14- cognition intact; *No depression reported; and, *The resident did not have hallucinations, psychosis, or delusions.</p> <p>On 9/10/13 a Permission for use of Psychopharmacological Medications and Sedative/Hypnotics (PPMS/H) form in Resident #14's record documented the resident was on Seroquel. Possible side effects included sleepiness, nausea, and dizziness.</p> <p>On 9/19/13 a second PPMS/H form documented the addition of lethargy as a possible side effect.</p> <p>The Black Box warning for Seroquel according to the Nursing 2013 Drug Handbook, Lippincott Williams &amp; Wilkins Page 1153 is documented as, "Drug isn't indicated for use in elderly patients with dementia-related psychosis because of increased risk of death from CV [cardiovascular] disease or infection." Note: The PPMS/H forms did not document Resident #14 or the resident's representative was informed of the Black Box warning.</p> <p>The resident's Initial Antipsychotic Medication assessment dated 9/13/13, documented: "Medications being considered: Seroquel." "Specific Diagnosis Requiring Antipsychotic Medication Use: Parkinson's dementia with associated psychosis with hallucinations." "Have the following potential causes...been ruled out: Lab abnormalities...(see lab results): none." "Has the pharmacist consultant ruled out...medication causes of the above problems:</p>	F 329	<p>treatment for depression is being considered, other medications are tried, and other potential causes are being ruled out.</p> <p><b><u>Monitor</u></b></p> <p>Starting on 6/20/14, the RN care managers will audit weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure residents receiving Psychopharmacological medications have received Black Box warnings by the pharmacist and audit to ensure required AIMS assessments are being completed.</p> <p>Starting on 6/20/14, Social Services Director will audit weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure behavioral interventions are in place, treatment for depression is being considered, and care plans updated to reflect resident behavior.</p> <p>Audit results will be reported to the monthly QI meeting for further monitoring and plan modification.</p> <p><b><u>Date of Compliance</u></b></p> <p>June 27, 2014</p>	

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE</b> <b>BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 29</p> <p>Yes."</p> <p>"List...medications tried in the past that have failed to achieve the desired goal in treating symptoms: None."</p> <p>"Since depression may exacerbate dementia and other disorders, has potential for depression been considered: Has an attempt to treat a possible depression been tried? None."</p> <p>"What "Behavioral interventions have been tried...? None."</p> <p>"Describe how the behavior...or endangering others or the resident. None."</p> <p>"What is the acceptable goal of therapy and when will it be re-evaluated: Decrease in hallucinations."</p> <p>Note: The form documented the resident had no behavioral interventions, no other treatment for possible depression, no other medications tried, or other potential causes ruled out. There was no documentation of less restrictive interventions or how the resident's behavior posed a risk to self or others.</p> <p>The resident's May 2014 MAR documented beginning 12/6/13: "Quetiapine Fumarate Tablet: Give 50 mg by mouth at bedtime related to hallucinations."</p> <p>On 5/22/14 at 9:45 AM, SSD #8 was interviewed about the resident's Care Plan. SSD #8 stated, "The Care Plan is the plan that came with him from [name of previous facility]. When interviewed SSD #8 was asked if she updated the Care Plan to reflect and/or monitor the resident's behaviors. SSD #8 stated, "No." SSD #8 was asked if she observed the resident's hallucinations. SSD #8 stated, "I did not see any hallucinations." SSD #8 stated, "The family was not informed of the Black Box Warning and there</p>	F 329			

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE</b> <b>BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 30</p> <p>is not any documentation in the file indicating the family had been notified."</p> <p>On 5/23/14 at 8:30 AM, the Administrator and DON were informed of the findings. No additional information was provided.</p> <p>2. Resident #4 was admitted to the facility on 5/2/14 with diagnoses that included dementia with Lewy Bodies, and dementia with behavioral disturbances.</p> <p>The resident's AIMS, dated 5/2/14, documented 0.0, which indicated the resident did not have involuntary movements.</p> <p>The resident's Permission for use of Psychopharmacological Medications and Sedative / Hypnotics dated 5/5/14, documented: *Medications: "Seroquel." *Side Effects: "dizziness, rhinitis." *Medication: "Trazodone." *Side Effects: "drowsiness, dry mouth." Signature of Resident (if resident unable to sign, state reason): "T.O [telephone order] [daughter's name documented]." *Relationship of signatory to resident: "Daughter." *Signature of Witness: [Name of unit manager.] *NOTE: The resident or family were not provided the information on the Black Box warning for Seroquel, which would state, "Drug isn't indicated for use in elderly patients with dementia-related psychosis because of increased risk of death from CV [cardiovascular] disease or infection." Nursing 2013 Drug Handbook, Lippincott Williams &amp; Wilkins page 1153.</p> <p>The resident's Physician admission and physical examination dated 5/5/14, documented:</p>	F 329		

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE</b> <b>BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 31</p> <p>*History of present illness: "The patient has an underlying diagnosis of Lewy body dementia per prior record coming from [Hospital name]. He has been living at [Name of Assisted Living facility]. Apparently he has had significant behavioral issues and wandering, even outside in his neighborhood. He did require a sitter in the hospital secondary to behavioral issues and agitation. Since his admission 3 days ago, the patient has had some significant behavioral issues surrounding nonspecific agitation, belligerence, refusals of care and physically being combative and striking out at staff. Out of necessity, yesterday he was given 1 mg [milligram] of haloperidol intramuscularly and prior dosages of quetiapine[Seroquel] were increased and Trazodone was also initiated."</p> <p>A second Permission for use of Psychopharmacological Medications and Sedative / Hypnotics dated 5/6/14, documented: *Medication: "Sertraline" *Side Effects: "Fatigue, dry mouth myalgia." *Signature of Resident (if resident unable to sign, state reason): "T.O [daughter's name documented]. *Relationship of signatory to resident: "Daughter." *Signature of Witness: [Name of unit manager.]</p> <p>The resident's physician recap orders dated 5/20/14, documented: *Seroquel Tablet Give 25 mg by mouth one time a day. Seroquel Tablet Give 50 mg by mouth one time a day for Dementia with Lewy Body and Dementia with behavioral disturbances. *Sertraline HCL [hydrochloride] 50 mg by mouth one time a day for Dementia related to Dementia with Lewy body and Dementia with behavioral disturbances.</p>	F 329		

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE</b> <b>BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 32</p> <p>*Trazodone HCL tablet. Give 25 mg by mouth one time a day. Give 50 mg by mouth one time a day for Dementia related to Dementia with Lewy body and Dementia with behavioral disturbances.</p> <p>On 5/21/14 at 11:00 am, the surveyor asked UM #5 and LN #4 what were the behaviors the resident had exhibited while in the facility. LN#5 stated, "He has hit and kicked staff." LN #6 stated, "He refuses cares. We would turn him on his sides and he would go back. We would put a pillow under him and he would move it." UM #5 stated, "In fact [MD's name] started him on a medication for the hitting and kicking," and then showed the MD progress note of 5/5/14 to the surveyor. The surveyor asked UM #5 if she was referring to the Seroquel and she stated, "Yes. We have started to decrease the Trazodone, because we find he does better if we let him sleep in the mornings." The surveyor asked UM #5 who was responsible to provide the Risks and Benefits of Psychotropic medications to the residents. UM #5 stated, "I notify them and get consent. I did it over the phone with [resident's daughter's name] for the alarms and everything."</p> <p>On 5/21/14 at 12:58 pm, 1:45 pm, 2:50 pm and 3:35 pm the resident was observed in bed sleeping soundly and snoring.</p> <p>On 5/21/14 at approximately 3:40 pm, the surveyor asked UM #5 if the resident had been sleeping a lot today. UM #5 stated "Yes, he is. Some days he will do this, sleeps all day and then the next day he doesn't." The surveyor asked for the Initial Antipsychotic Medication Assessment and AIMS form completed by the LN per the facility's policy. UM #5 looked on the computer and stated, "The nurse should have done the</p>	F 329			

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE</b> <b>BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 33</p> <p>assessment and I know I did the AIMS." UM #5 verified the AIMS was completed and stated, "I don't see one. I will have to do one late. [Initial Assessment]." The surveyor reviewed the Permission for Use of Psychopharmacological Medication form with UM #5. The surveyor asked if it was the form she provided to residents to inform them of the risks and benefits for use of the psychotropic medications. UM #5 verified it was. The surveyor asked if there was documentation that the resident or family had been provided information on the Black Box warning for Seroquel. UM #5 stated, "We don't do that as nurses." The surveyor asked who was responsible to provide the information to the resident and family, and the UM stated, "The physician." The surveyor asked if there was documentation that the MD had provided the information to the resident or family. UM #5 looked through the resident's chart and verified the Physician had not provided the information to the resident or family.</p> <p>On 5/21/14 at 3:55 pm, 4:55 pm, 5:35 pm, 6:00 pm, the surveyor observed the resident in bed asleep and snoring.</p> <p>On 5/22/14 at 8:30 am, the surveyor observed the resident asleep.</p> <p>On 5/22/14 at 11:15 am, the surveyor asked Social Worker (SW) #8 if she had provided information on psychotropic medication to residents or families which would include Black Box warnings; she stated, "I thought it would be the nurse. We use to have a sticker with Black Box warnings." The surveyor reviewed the Permission for Use of Psychopharmacological Medications form with her, and asked her if she</p>	F 329			

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE</b> <b>BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 34</p> <p>had a part in filling it out. SW #8 stated, "I am not involved in this. I don't explain it, I am not a nurse." The surveyor asked if the resident had slept a lot since the medication adjustments on 5/5/14. The SW stated, "He was very agitated when he came in, so we got him a 1 on 1 sitter. At times he is somnolent and other times he is up at meals and at therapy."</p> <p>On 5/22/14 at 2:35 pm, the surveyor reviewed the Permission for Use of Psychopharmacological Medications form for the resident with the DON. The surveyor asked if the adverse reactions of Seroquel, which would include the Black Box warning, somnolence, agitation, anorexia, drowsiness, and sedation were included on the form, and if it would be important for the resident and family to know this information. The DON agreed the adverse reactions would be important information to the resident and family, and acknowledged were not documented on the form. NOTE: The adverse reactions for Seroquel discussed with the DON are documented in the Nursing 2013 Drug Handbook, Lippincott Williams &amp; Wilkins page 1153 and were not provided to the resident or family.</p> <p>On 5/22/14 at 4:45 pm, the Administrator and DON were informed of the findings. No additional information was provided.</p> <p>3. Resident #11 was admitted to the facility on 4/20/12 and readmitted on 3/19/13 with multiple diagnoses including generalized pain, anxiety, asthma and dysthymic disorder.</p> <p>Resident #11's most recent significant change MDS assessment dated 2/27/14, documented the resident:</p>	F 329		

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE</b> <b>BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 35</p> <ul style="list-style-type: none"> <li>*Was moderately cognitively impaired;</li> <li>*Was minimally depressed;</li> <li>*Had no behavioral symptoms or rejection of cares; and</li> <li>*Had occasional moderate pain.</li> </ul> <p>The resident's Physician orders dated 5/20/14 included an order for alprazolam tablet. "Give 0.25 mg by mouth as needed for anxiety PRN 3X daily," with a start date of 3/19/13.</p> <p>The resident's Care Plan included a focus area "[Resident #11] has behavioral symptoms [related to] anxiety, initiated on 12/11/13." The Goals were "[Resident #11] will have less than 4 episodes of anxiety monthly by review date." Interventions included "Attempt non-pharmacological interventions 1:1 support from staff or S.S. [social services]."</p> <p>Note: No behavioral symptoms related to anxiety were described and no other interventions were provided to address anxiety.</p> <p>The resident's Intervention Flowsheets were reviewed for March, April and May 2014. The intervention was documented, "Non-pharmacological: attempt non-pharmacological intervention 1:1 support from staff or s.s." However, nothing was documented on these forms.</p> <p>Resident #11's interdisciplinary Progress Notes documented: -3/5/14 at 5:26 PM, "Alprazolam...requested by resident [by mouth] per orders Alprazolam 0.25 mg administered at this time." -3/19/14 at 7:24 AM, "Alprazolam. Give one tab ... Increased anxiety with left hip/groin pain." Note: Pain was not assessed in the Progress</p>	F 329		

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE</b> <b>BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 36</p> <p>notes or MAR at this time and no PRN pain medications were given. Only PRN alprazolam was given.</p> <p>-3/20/14 at 11:46 PM, "Alprazolam... Requested for increased anxiety [related to] not being able to sleep."</p> <p>-3/29/14 at 6:12 PM, "Resident complaining of anxiety and requested Xanax and given."</p> <p>-4/13/14 at 11:30 PM, "Alprazolam...resident requested for anxiety."</p> <p>-4/27/14 at 9:55 AM, "Alprazolam tab. Give 0.25 mg by mouth as needed for anxiety prn 3X daily."</p> <p>-5/5/14 at 12:55 AM, "Alprazolam tab... Requested for anxiety."</p> <p>Note: Under each administration was documented an E for "Effective."</p> <p>-5/12/14 at 11:20 AM, "Behavioral Review Form...Medications: psychopharmacological meds and sedative/hypnotics tracking tool. Target behavior: 1.Rejection of cares. 2.Being short tempered easily annoyed. 3.Feeling anxious... Intervention: Leave and re-approach, provide 1:1 with resident. Summary: [Resident #11] had no mood or behavioral changes in January or February. [Resident #11's Physician] will continue to follow for any changes to her care plan goals.</p> <p>-5/12/14 at 11:24 AM, "Behavioral Review Form...Medications: psychopharmacological meds and sedative/hypnotics tracking tool. Target behavior: 1.Rejection of cares. 2.Being short tempered easily annoyed. 3.Feeling anxious... Intervention: Leave and re-approach, Provide 1:1 with resident. Summary: [Resident #11] had no mood or behavioral changes in March and April. [Resident's Physician] will continue to follow for any changes to her care plan goals.</p> <p>The resident's Intervention Flowsheets were reviewed for March, April and May 2014. The</p>	F 329			

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE</b> <b>BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	Continued From page 37 intervention was documented, "Non-pharmacological: attempt non-pharmacological intervention: 1:1 support from staff or s.s." However, nothing was documented on these forms. No other behavior monitoring or documentation regarding the resident's anxiety was found.  On 5/21/14 at 5:05, UM #3 was interviewed regarding Resident #11. When shown the lack of documentation for non-pharmacological anxiety interventions for Resident #11, the UM said, "That's the problem with this new system. It's difficult to document. It doesn't look like anything has been charted in the electronic medication record for her." When asked what Resident #11's anxiety looks like she said, "I think shortness of breath. She gets overwhelmed with her spinal stenosis related to pain and then becomes short of breath." When the surveyor showed the lack of documentation or monitoring related to pain or shortness of breath she said, "She doesn't always complain of pain and she wouldn't tell everyone about the pain. She has different relationships with different staff members. She tells people different things." Note: Pain and shortness of breath were not addressed on the care plan as symptoms to be assessed when the resident reported feeling anxious.  On 5/22/14 at 4:45 pm, the Administrator and DON were informed of the findings. No additional information was provided	F 329			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an	F 441	<b>F441 – Infection Control, Prevent Spread, Linens</b>	<b>6/27/14</b>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/23/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 441	<p>Continued From page 38</p> <p>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</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 interviews, it was</p>	F 441	<p><b><u>Resident Specific</u></b></p> <p>On 5/21/14, the RN care manager and consistent assignment caregiver changed the Foley bag cover and corrected resident # 19's Foley bag position so it no longer rested on the floor.</p> <p>The ice machine that was contaminated by resident #20 was cleaned immediately.</p> <p>Resident #21 and other residents will no longer have access to the clothing protectors.</p> <p><b><u>Other Residents</u></b></p> <p>All residents with Foley bags, access to ice machines and who utilize clothing protectors have the potential to be affected by this practice.</p> <p><b><u>Facility System</u></b></p> <p>Nursing staff will be in-serviced by 6/26/14 regarding the proper placement of Foley bags and interventions if bag is incorrectly placed, monitoring ice machines, and ensuring clothing protectors are handled by staff only.</p> <p>There will be hand sanitizer available at each ice machine. Nursing staff will be</p>	
-------	---	-------	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 39</p> <p>determined the facility failed to ensure the implementation of proper infection control measures related to:</p> <ul style="list-style-type: none"> <li>*Preventing Foley catheter bags from lying on the floor;</li> <li>*Preventing a resident from contaminating an ice machine accessible to all residents and visitors; and</li> <li>*Preventing a resident from contaminating clean clothing protectors utilized by residents during meal times.</li> </ul> <p>This was true for 3 random residents (#s 19, 20 and 21). These practices created the potential for more than minimal harm if infection were to spread from unsanitary practices. Findings include:</p> <p>1. On 5/19/14 at 2:00 PM, Resident #19's Foley bag was observed to be face down on the floor beside her bed. CNA #7 was shown the finding and said, "That happens every once in a while," and placed the Foley in the privacy bag and hooked it onto the bed frame so it no longer rested on the floor.</p> <p>On 5/19/14 at 2:55 PM, Resident #19's Foley bag was observed to be in the privacy bag resting on the floor, still hooked to the bed frame.</p> <p>On 5/21/14 at 5:30 PM, Resident #19's Foley bag was observed to be in the privacy bag resting on the floor, still hooked to the bed frame. The UM #3 was shown the finding and said, "A recent intervention for this resident after her fall was to lower her bed, so now the Foley rests on the floor. Thanks for bringing this to my attention." The UM and CNA #4 fixed the Foley bag and moved it so it no longer rested on the floor.</p>	F 441	<p>responsible for educating, observing and assisting residents who use the ice machines. The ice machines have been put on review by Environmental Services to ensure they work properly.</p> <p>The cabinet in the main dining room containing clothing protectors will be locked and only staff will be allowed access to the locked cabinet.</p> <p><b><u>Monitor</u></b></p> <p>Starting on 6/20/14, the RN care managers will audit weekly x4, bi-weekly x4, and monthly x3 to ensure Foley bags are properly placed, ice machines are being monitored, and clothing protectors are being handled by staff only. Audit results will be reported to the monthly QI meeting for further monitoring and plan modification.</p> <p><b><u>Date of Compliance</u></b></p> <p>June 27, 2014</p>	

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 40</p> <p>2. On 5/19/14 at 1:55 PM, Resident #20 was observed getting ice out of the ice machine. The resident placed his mug up to the valve of the ice machine which touched the lip of his cup. The ice became jammed and the resident stuck his finger up the valve to release the ice.</p> <p>On 5/19/14 at 2:15 PM, the surveyor interviewed Resident # 20 and asked if he had received training on how to get ice out of the ice machine. Resident #20 stated, "Yes." The survey asked the resident about using his finger to release the ice and if he was instructed to release the ice with his finger. The resident stated, "I know I'm not supposed to do it but I don't care."</p> <p>On 5/19/14 at 2:55 PM, the surveyor asked UM #5 about the above said incident. UM #5 stated, "We invite residents to be self sufficient. When they are observed....the area is wiped down with a sanitizing solution and a conversation takes place with the resident about proper procedures."</p> <p>On 5/19/14 at 3:10 PM, the surveyor interviewed CNA #12 and asked about staff training regarding contamination of the ice machine. CNA #12 stated, "We have been trained and educated on what to do in the event of contamination of the ice machine or other objects. We clean the surface with a sanitizing solution."</p> <p>On 5/23/14 at 8:30 AM, the Administrator and DNS were informed of the contamination issues. However, no further documentation was provided.</p> <p>3. On 5/21/14 at 5:30 PM during the dinner meal observation, a cabinet was observed on the east side of the main dining room. Resident #21</p>	F 441		

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

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE</b> <b>BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 41 approached the cabinet and opened the door. The cabinet contained stacks of clothing protectors. Resident #21 reached in the cabinet and began to move the stacks of clothing protectors around with her bare hand. She handled several of them from each stack, taking them out, unfolded them and refolded them, before selecting one and taking it with her to her table.  At 5:35 PM, UM #3 was asked about resident access to the clothing protectors, and how the facility assured the residents' hands were clean before they accessed the cabinet. UM #3 stated many of the residents typically accessed the cabinet to retrieve a clothing protector if they wanted one. UM #3 was asked how the facility ensured the residents' hands were clean when they accessed the cabinet. UM #3 stated, "That's a good point. I just thought they grabbed the one they were going to use. I hadn't thought about whether they were touching others."	F 441			
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS  The facility must equip corridors with firmly secured handrails on each side.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all corridors were equipped with handrails. This	F 468	<b>F468 – Corridors have firmly secured Handrails</b>  <b><u>Resident Specific</u></b>  The handrails from the 200 hallway into the Eagle Unit have been replaced, which will provide handrail stability for residents #2, 8, and 10.	<b>6/27/14</b>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 468	<p>Continued From page 42</p> <p>affected 3 of 15 (#s 2, 8, &amp; 10) sampled residents and had the potential to affect other residents who frequented the corridors without handrails. This practice created the potential for residents to not have a handrail for stability when needed. Findings included:</p> <p>On 5/19/14 at 9:15 AM, approximately 20 feet on the right side and 5 feet on the left side of the corridor from the 200 hallway into the Eagle Unit were observed to be missing.</p> <p>On 5/21/14 at 1:11 PM, the Environmental Services Director was shown the missing handrails and he stated, "I see that." He then stated, "That's easily fixed."</p> <p>On 5/21/14 at 6:05 PM, the Administrator and DNS were informed of the issue. No other information was provided.</p>	F 468	<p><b><u>Other Residents</u></b></p> <p>All residents have the potential to be affected when facility corridors are not equipped with handrails.</p> <p><b><u>Facility System</u></b></p> <p>The hand rails have been replaced for the area identified between the 200 hallway and the Eagle Unit.</p> <p><b><u>Monitor</u></b></p> <p>Starting on 6/20/14, the Environmental Services Director will audit weekly x4, bi-weekly x4, and monthly x3 to ensure all corridors are equipped with handrails. Audit results will be reported to the monthly QI meeting for further monitoring and plan modification.</p> <p><b><u>Date of Compliance</u></b></p> <p>June 27, 2014</p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001060</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGI</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

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 survey of your facility.  The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Susan Gollobit, RN Nina Sanderson, BSW, LSW Jana Duncan, RN, MSN Noel Mathews, MSW Judy Atkinson, RN	C 000	<b>General Disclaimer</b>  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 147	02.100,05,g Prohibited Uses of Chemical Restraints  g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician. This Rule is not met as evidenced by: Please refer to F329 as it pertains to psychotropic drugs.	C 147	<b>C 147 – Prohibited Uses of Chemical Restraints</b>  Please refer to Plan of Correction for F329.	<b>6/27/14</b>
C 173	02.100,12,d Immediate Notification of Physician of Injury  d. The physician shall be	C 173	<b>C 173 – Immediate Notification of Physician of Injury</b>	<b>6/27/14</b>

RECEIVED  
JUN 20 2014  
FACILITY STANDARDS

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

TITLE  
*Administrator*

(X6) DATE  
*6/20/14*

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001060</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGI</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 173	Continued From page 1  immediately notified regarding any patient/resident injury or accident when there are significant changes requiring intervention or assessment. This Rule is not met as evidenced by: Please refer to F 157 as it pertains to physician notification.	C 173	Please refer to Plan of Correction for F157.	
C 175	02.100,12,f Immediate Investigation of Incident/Injury  f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Please refer to F225 as it refers to abuse.	C 175	<b>C 175 – Immediate Investigation of Incident/Injury</b>  Please refer to Plan of Correction for F225.	<b>6/27/14</b>
C 389	02.120,03,d Sturdy Handrails on Both Sides of Halls  d. Handrails of sturdy construction shall be provided on both sides of all corridors used by patients/residents. This Rule is not met as evidenced by: Refer to F468 related to missing handrails.	C 389	<b>C 389 – Sturdy Hand Rails on Both Sides of Halls</b>  Please refer to Plan of Correction for F468.	<b>6/27/14</b>
C 645	02.150,01,a,ii CARE OF EQUIPMENT  ii. Care of equipment. This Rule is not met as evidenced by: Please refer to F441 as it pertains to infection control practices.	C 645	<b>C 645 – Care of Equipment</b>  Please refer to Plan of Correction for F441.	<b>6/27/14</b>
C 650	02.150,01,a,vii Resident Care Practices	C 650	<b>C 650 – Resident Care Practices</b>	<b>6/27/14</b>

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001060</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGI</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 650	Continued From page 2  vii. Resident care practices, i.e., catheter care, dressings, decubitus care, isolation procedures. This Rule is not met as evidenced by: Please refer to F441 as it pertains to foley care.	C 650	Please refer to Plan of Correction for F441.	
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: Please refer to F 280 as it pertains to care plans.	C 782	<b>C 782 – Reviewed and Revised</b>  Please refer to Plan of Correction for F280.	<b>6/27/14</b>
C 784	02.200,03,b Resident Needs Identified  b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F309 as it pertains to the Baclofen pump.	C 784	<b>C 784 – Resident Needs Identified</b>  Please refer to Plan of Correction for F309.  <b>C 875 – Examination of Pets</b>  <b><u>Resident Specific</u></b>  Veterinarian records and vaccination records were obtained on 6/20/14 for resident #22's bird. These records are stored in the Social Services Director/Quality Assurance Coordinator's office.	<b>6/27/14</b>
C 875	02.202,03 EXAMINATION OF PETS  03. Examination of Pets. Pets shall receive an examination by a veterinarian prior to admission to the facility. Appropriate vaccinations shall be given. Birds subject to transmission of psittacosis are included. This Rule is not met as evidenced by:	C 875	<b><u>Other Residents</u></b>  The failure to ensure that a domestic bird in the facility had a Veterinarian	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001060</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/23/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGI</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 875	<p>Continued From page 3</p> <p>Based on staff interview it was determined the facility failed to ensure that a domestic bird in the facility had a Veterinarian examination and vaccinations prior to admission to the facility. This failure created the potential for a negative effect for all residents, staff and visitors in the facility should the bird have an illness which would be spread to individuals in contact with the bird. Findings included:</p> <p>On 5/22/14 at approximately 10:25 am, during the Environmental tour, the Environmental Director [ED] was asked by the surveyor if there were animals in the facility. The ED stated there was a dog, a cat and a bird. The surveyor asked for the Veterinarian record for the animals and the ED stated [Social Service Director/Quality Improvement Coordinator name] would have those records.</p> <p>On 5/22/14 at 11:15 am, the Social Service Director/ Quality Improvement Coordinator [SSD/QIC], was asked by the surveyor for the Veterinarian records for the dog, cat and the bird. SSD/QIC stated, "I don't have anything on the bird. I can ask the family if they do." She verified the bird belonged to resident #22, and resided in his room. At 1:37 pm, the SSD/QIC provided Veterinarian records for the dog and cat, and verified the facility did not have Veterinarian records for the bird.</p> <p>On 5/22/14 at 4:45 pm, the Administrator and the DON were informed of the findings. No additional information was provided.</p>	C 875	<p>examination and vaccinations prior to admission to the facility had the potential to affect all residents.</p> <p><b><u>Facility System</u></b></p> <p>The Social Services Director/Quality Assurance Coordinator and Activities/Volunteer Director will be in-serviced by 6/26/14 regarding the need for a Veterinarian examination and vaccinations prior to the admission of any animal into the facility. The Social Services Director/Quality Assurance Coordinator will maintain these records in her office.</p> <p><b><u>Monitor</u></b></p> <p>Starting on 6/20/14, the Social Services Director/Quality Assurance Coordinator will audit weekly x 4, bi-weekly x 4, and monthly x3 to ensure any pet being admitted to the facility will have a Veterinarian examination and vaccination records prior to admission and as requests from residents to bring their domestic pets to the Center occur. Audit results will be reported to the monthly QI meeting for further monitoring and plan modification.</p> <p><b><u>Date of Compliance</u></b></p> <p>June 27, 2014</p>	



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  
FAX 208-364-1888

June 9, 2014

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

Provider #: 135085

Dear Mr. Davidson:

On **May 23, 2014**, a Complaint Investigation survey was conducted at Good Samaritan Society - Boise Village. Bradley Perry, L.S.W., Susan Gollobit, R.N., Nina Sanderson, L.S.W., Jana Duncan, R.N. and Noel Mathews, L.S.W. conducted the complaint investigation. This complaint survey was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted on May 19 through May 23, 2014.

The following observations were conducted:

- Observations were made of the identified resident and other sample residents throughout the survey process.

The following documents were reviewed:

- The entire medical record of the identified resident and three other residents with compromised skin conditions;
- The facility's policy and procedure regarding wound documentation; and
- The facility's grievance file.

The following interviews were conducted:

- Six residents were interviewed at a group interview regarding quality of care issues;

- Four individual residents were interviewed regarding quality of care issues;
- Two resident's family members were interviewed regarding quality of care issues;
- The Director of Nursing Services (DNS) was interviewed regarding wound documentation procedures and quality of care issues; and
- An identified staff member and an additional staff member were interviewed regarding wound documentation procedures.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006375**

**ALLEGATION #1:**

The complainant said an open wound was identified in an identified resident's gluteal cleft and documented by a licensed nurse (LN) on January 16, 2014. The complainant stated the LN was told to change the original charting by the DNS to a skin tear on the buttocks.

**FINDINGS:**

The identified resident still lives at the facility. An entry regarding an open wound was made in the resident's record on the date specified in the complaint, and was stricken 20 minutes later per the computerized time stamp in the record. A similar note was made at the time the first note was stricken, also regarding an open wound. A note made by another nurse later that same date clarified the nature of the wound to be a skin tear.

The DNS was interviewed regarding the resident. The DNS stated she was unaware a note had been stricken from the resident's record, but stated if a nurse felt they had made an error in documentation, the note could be stricken from the record and a new entry made. The DNS stated it would not be necessary for a nurse to inform her when and if an incorrect entry had been made, as there was a process in place by which the nurse could correct the error. After reviewing the resident's record with the surveyor, the DNS stated there appeared to be a stricken entry in the resident's record, along with a similar entry made 20 minutes later. The DNS stated she could not be certain why the entry had been stricken, as she had been unaware of it until the surveyor asked about it. She stated she did not recall the specific entry, but stated she had not and would not instruct a nurse to change documentation.

The identified staff member was interviewed regarding the resident. The identified staff member stated the original entry contained a small error, and by the time they realized it had been made, the only way to correct it was to strike the original note and enter a new one. The identified staff member stated they had not consulted the DNS regarding this matter, as they were acting within

Brian J. Davidson, Administrator  
June 9, 2014  
Page 3 of 4

documentation principles of nursing care and the facility's policy. The identified staff member stated they were not instructed by the DNS to change the documentation. The identified staff member stated the issue on the resident's buttocks was clearly a skin tear.

Based on records reviewed and staff interviews, it was determined the facility was in compliance with Federal guidelines.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated that two LNs charted there was a "size of the wound" on January 29 and January 30, 2014, when the wound had closed. The complainant was concerned that strikeouts and errors in documentation were not made in the identified resident's chart. The facility has electronic documentation and strike out errors should have been made in the identified resident's chart.

FINDINGS:

The identified resident's record contained an entry stating the wound was closed on a specific date. For the next two days, the resident's record documented the site of a skin tear was being monitored, but the skin tear had closed. No size of the skin tear was documented. At that time, the resident's physician provided an order for the facility to stop documenting on the skin tear, as it had healed. The resident's record contained no further documentation on this issue.

Based on records reviewed and staff interviews, it was determined the facility was in compliance with Federal guidelines.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated that in January or February of 2014, charting was changed on an unidentified resident's chart by an unidentified LN to reflect a skin condition that was different from what was observed by unidentified nursing staff. The complainant was unable to give names of residents or staff members involved.

Brian J. Davidson, Administrator  
June 9, 2014  
Page 4 of 4

FINDINGS:

Due to the lack of details available, it was not possible to investigate or substantiate this portion of the complaint.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The letters are somewhat stylized and connected.

LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor  
Long Term Care

LKK/dmj