



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 208-364-1868

**CERTIFIED MAIL: 7007 3020 0001 4038 8560**

June 27, 2013

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

Provider #: 135085

Dear Mr. Davidson:

On **June 12, 2013**, we conducted an on-site follow-up revisit to verify that your facility had achieved and maintained compliance. We had presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **April 12, 2013**. However, based on our on-site follow-up revisit conducted **June 12, 2013**, we found that your facility is not in substantial compliance with the following participation requirements:

**F0314 -- S/S: G -- 483.25(c) -- Treatment/sves To Prevent/heel Pressure Sores**

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. **Please provide ONLY ONE completion date for each federal and state tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance.** After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your copy of the Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

Brian Davidson, Administrator

June 27, 2013

Page 2 of 4

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 9, 2013**.

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

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

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

- 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.

Brian Davidson, Administrator

June 27, 2013

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

As noted in the letter of **March 27, 2013**, following the survey of **March 15, 2013**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions on June 15, 2013, and termination of the provider agreement on **September 15, 2013**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

STATE ACTIONS effective with the date of this letter (**June 27, 2013**): None

If you believe the deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the POC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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

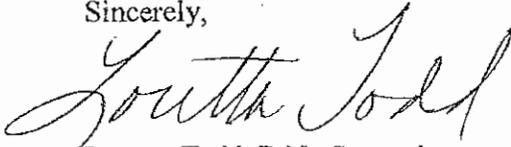
This request must be received by **July 9, 2013**. If your request for informal dispute resolution is

Brian Davidson, Administrator  
June 27, 2013  
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received after **July 9, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the on-site follow-up revisit. If you have any questions or concerns, please contact this office at (208) 334-6626.

Sincerely,

A handwritten signature in cursive script that reads "Loretta Todd". The signature is written in black ink and is positioned above the printed name and title.

Loretta Todd, R.N., Supervisor  
Long Term Care

LT/pt

Enclosures

cc: Survey, Certification & Enforcement Branch, Western Division of Survey & Certification,  
Seattle Regional Office

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

PRINTED: 06/27/2013  
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>R</b> <b>06/12/2013</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 000}	INITIAL COMMENTS  The following deficiencies were cited during the onsite follow up survey of your facility.  The surveyors conducting the survey were:  Karen Marshall, MS, RD, LD Team Coordinator Brad Perry, BSW, LSW Karla Gerieve, RN  Survey Definitions:  DON = Director of Nursing 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to prevent a Stage II pressure sore from developing. This was true for 1 of 2 (#3) residents reviewed for pressure ulcers. This had the potential to cause harm putting the resident at risk for infection and pain. Findings included:  Resident #3 was admitted on 7/10/11 with	{F 000}	<b><u>General Disclaimer</u></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.  <b>F314 – Treatment / Services to prevent / Heal Pressure Sores</b>  <b><u>Resident Specific</u></b>  The documentation has been completed for Resident #3 on 6/14/13 to include updating the progress notes, reviewing the Braden Scale and revising the care plan. Appropriate interventions were followed for both the blister and bruise prior to resident expiring on 6/22/13.  <b><u>Other Residents</u></b>  All residents have the potential to be		
{F 314} SS=G		{F 314}		8/1/2013 <del>6/21/13</del>	

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

*Brian A. Davida*

TITLE

*Administrator*

(X6) DATE

*7/2/13*

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

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{F 314}	<p>Continued From page 1</p> <p>diagnoses of vascular dementia with depression, and aftercare for a healing traumatic fracture of the right pubic rami (ramous) and right 5th metacarpal.</p> <p>Resident #3's most recent Significant Change MDS assessment dated 5/21/13 documented in part:</p> <ul style="list-style-type: none"> <li>- at risk of developing pressure ulcers</li> <li>- a pressure reducing device on chair and bed and on a turning/repositioning program</li> </ul> <p>Resident #3's most recent CAA (Care Area Assessment) dated 5/21/13 documented Pressure Ulcer would be proceeded to care planned for the prevention of skin break down.</p> <p>Resident #3's Braden Scale Reference Tool (backside of the Braden Scale for Predicting Pressure Sore Risk), documented a score of 15-18 as a mild risk for developing a pressure sore. NOTE: The form did not indicate a level of risk for a score of 19. Resident #3's "Braden Scale for Predicting Pressure Sore Risk" form documented the following: 9/26/12 - 19; 12/21/12 - 18; 3/12/13 - 18; and 5/20/13 - 17. One of the interventions for a score of 15 - 18 was to, "protect heels."</p> <p>Resident #3's 3/19/13 Care Plan had a problem for "Potential for skin impairment r/t BLE [related to bilateral lower extremity] edema, anemia, history of breast cancer, decreased mobility, inc b&amp;b [incontinent of bowel and bladder]." On 6/11/13 "Palliative care" was added to this problem. Plans and approaches were documented as follows: "check skin daily with AM/PM cares, report concerns to LN [Licensed</p>	{F 314}	<p>affected and have been assessed to identify any skin issues with the results being documented in the chart.</p> <p><b><u>Facility System</u></b></p> <p>The RN Care Managers and nursing staff were re-educated regarding skin assessments, updating the care plans, proper notification, investigation, treatment, and documentation process.</p> <p>The Interdisciplinary Team (IDT) is having weekly Skin-At-Risk (SAR) meetings to ensure skin assessments, treatments, reporting, investigations, and documentation have been completed.</p> <p><b><u>Monitor</u></b></p> <p>The RN Care Managers will audit care plans, IDP notes, treatment sheets, approaches, and the Braden Scales weekly x4, bi-weekly x4, and monthly x3 to ensure all skin issues have been addressed. 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 21, 2013.</p>	

*Alleged completion date changed by the administrator via email's only*

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 314}	Continued From page 2 Nurse]; LN to do skin check & nail care Q WK [every week]; each x1[one nurse aide] for reposition Q 2 hours & PRN QS [and as needed q shift] when fatigued; and alternating pressure mattress & pressure redistribution cushion to W/C [wheelchair]."  Interdisciplinary Progress Notes documented in part: 6/4/13-8:00 pm "[Doctor's name] ordered labs....on next lab day. Res[ident] has bruise under left heel and sore to touch. No edema noted this shift." 6/5/13-3:00 pm "Call placed to [family member] regarding [Resident #3's] decline" 6/10/13-10:00 am "Fluid filled blister noted on right heel. Will monitor Q shift." 6/10/13-11:00 am "Blister probably was caused by the pedals on her w/c." 6/10/13-8:00 pm "Order received for palliative care-end of life per [doctor's name]"  Resident #3 had an "Initial/Temporary Narrative Care Plan" dated 6/10/13 added to the existing Care Plan. The Temporary Care Plan documented, "Blister right heel, will resolve in the next 14 days, bilateral boots on at all times except for cares, reposition Q 2 hours, and resident usually will not turn to the side, prefers to sleep on back."  Resident #3's June 2013 Treatment Administration Record (TAR) documented in part: -"7/10/11 Skin Monitor Q Week," This monitor was checked as done on 6/07/13. No documentation was found that followed up the bruise found on 6/04/13 on the left heel. -"6/10/13 monitor blister right heel q shift"	{F 314}			

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{F 314}	<p>Continued From page 3 - "6/10/13 Palliative Care Info[rmation]."</p> <p>Resident #3's 6/10/13 Wound Flow Sheet (weekly skin check) documented in part: - a Stage II on the right heel - 3.5 x 3.5 with 0% epithelialized and 0% granulation tissue - "Blister-in dying process, not eating" - signed by RCUM #1 on 6/10/13</p> <p>On 6/12/13 at 9:00 am, the DON stated, "We have a resident with a blister on her heel. She is on end of life care."</p> <p>On 6/12/13 at 1:40 pm, Resident #3 was observed in her room, eyes closed, laying on an air mattress. A visitor was at Resident #3's bedside. The surveyor asked the visitor if she knew if Resident #3 had on "booties." The visitor lifted Resident #3's covers displaying light colored blue booties on the resident's feet. Resident #3's heels appeared to be suspended off the bed by the use of the blue booties.</p> <p>On 6/12/13 at 1:00 pm the RNUM#1 and the DON were interviewed. RNUM #1 said she found a bruise on Resident #3's left heel on 6/4/13 and she thought the bruise was caused by Resident #3's slippers. She said she did not initiate any further monitoring in place when she found the bruise. However, the resident's June 2013 TAR, as stated above indicated Resident #3's skin was monitored "Q Week." Then, on 6/10/13 the RNUM#1 said she found a blister on Resident #3's right heel, and the blue booties were placed on Resident #3's heels. RNUM #1 also said Resident #3 pushed her feet down on the wheelchair pedals. RNUM#1 said she felt like the</p>	{F 314}		

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{F 314}	<p>Continued From page 4</p> <p>blister on Resident #3's right heel was caused by the foot pedals on the wheelchair. RNUM#1 documented this in the progress notes listed above on 6/10/13 at 11:00 am.</p> <p>NOTE: According to Resident #3's "Initial/Temporary Narrative Care Plan" the blue boots were initiated after the blister on the right heel was discovered on 6/10/13.</p> <p>Resident #3 was found with a bruise to the left heel on 6/4/13. The facility did not initiate any devices to protect the resident's left or right heels on 6/4/13. On 6/10/13 Resident #3 developed a Stage II blister on the right heel, possibly due to the pressure on the resident's wheelchair pedals.</p> <p>On 6/12/13 at 2:30 pm, the DON and Administrator were informed of the concern of the Stage II pressure sore that had developed on Resident #3's right heel. No other information or documentation was provided which resolved this issue.</p>	{F 314}		

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>R</b> <b>06/12/2013</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>		
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{C 000}	16.03.02 INITIAL COMMENTS  The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the onsite follow up survey of your facility.  The surveyors conducting the survey were:  Karen Marshall, MS, RD, LD Team Coordinator Brad Perry, BSW, LSW Karla Gerleve, RN	{C 000}	<b><u>General Disclaimer</u></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 789}	02.200,03,b,v Prevention of Decubitus  v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Please refer to F314 as it related to development of a Stage II pressure ulcer.	{C 789}	<b>C 789 – Prevention of Decubitus</b>  Please see Plan of Correction for F314.	8/1/2013 dy 6/21/13

RECEIVED

JUL 03 2013

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Bureau of Facility Standards

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



TITLE  
*Administrato*

(X6) DATE  
**7/2/13**