



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 208-364-1886

CERTIFIED MAIL: 7012 1010 0002 0836 2397

August 6, 2013

David R. Bargmann, Administrator  
Good Samaritan Society - Silver Wood Village  
405 West 7th Street, PO Box 358  
Silverton, ID 83867-0358

Provider #: 135058

Dear Mr. Bargmann:

On **July 19, 2013**, a Recertification and State Licensure survey was conducted at Good Samaritan Society - Silver Wood Village by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be 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

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sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 19, 2013**. Failure to submit an acceptable PoC by **August 19, 2013**, may result in the imposition of civil monetary penalties by **September 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.

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- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **August 23, 2013 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **August 23, 2013**. A change in the seriousness of the deficiencies on **August 23, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 23, 2013** includes the following:

Denial of payment for new admissions effective **October 19, 2013**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 19, 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 Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

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If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **July 19, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

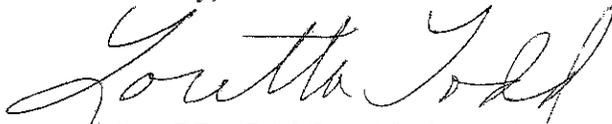
- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)  
[2001-10 IDR Request Form](#)

This request must be received by **August 19, 2013**. If your request for informal dispute resolution is received after **August 19, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,



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

LT/dmj  
Enclosures

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

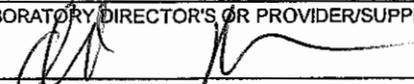
PRINTED: 08/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/19/2013
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST 7TH STREET SILVERTON, ID 83867
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS  The following deficiencies were cited during the annual recertification survey in your facility.  Survey Team Members: Nina Sanderson, BSW, LSW, Team Coordinator Linda Kelly, RN Lauren Hoard, RN  Survey Definitions: MDS = Minimum Data Set CAA = Care Area Assessment DNS/DON = Director of Nursing ADLs = Activities of Daily Living LN = Licensed Nurse H&P = History and Physical BIMS = Brief Interview of Mental Status MAR = Medication Administration Record SSD = Social Services Director OT = Occupational Therapist mg = Milligrams	F 000	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.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  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 resident interview, it was determined the facility failed to ensure call lights were available to all residents. This was	F 246	F246  1. Residents #4 and # 13 call lights are placed in reach.  2. All other Residents have the potential to be affected by this practice.	RECEIVED AUG 20 2013 FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 8/16/13
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 246	Continued From page 1 true for 1 of 8 sample residents (#4) and 1 random resident (#13). The failed practice created the potential for physical and possibly emotional harm for residents when their call light was not available if needed or wanted. Findings included:  1. On 7/15/13 at about 1:45 p.m., during the initial tour of the facility, Resident #13 was observed in bed and the resident's call light was observed on the floor next to the bed. When asked how she would summon help, the resident stated, "The red button." At this, the resident began to feel on the bed for the call light and stated, "I don't see it."  On 7/15/13 at about 1:50 p.m., Housekeeping Aide #1 accompanied the surveyor into Resident #13's room. When asked how the resident would summon help, the housekeeping aide noticed the call light on the floor and said, "Oh yeah." The housekeeping aide picked up the call light, clipped it to the bedrail, and draped the button end over the resident's lap.  2. On 7/15/13 at about 1:55 p.m., during an initial tour of the facility with LN #2 in attendance, Resident #4's bathroom call light was observed wrapped 3 times around the safety bar. The LN was unable to activate the call light system when she attempted to pull the call light cord below the safety bar. When asked if the Resident #4 used the bathroom, the LN said, "Yes."  On 7/18/13 at about 3:30 p.m., the administrator and the DON were informed of the call light issue. No other information or documentation were received from the facility that resolved the issue.	F 246	3. Staff members were in-serviced on call light use at all staff meeting 8/14/13.  4. Department heads/charge will check call light being in located in area for ease of use by the Resident. Monitoring will be daily x 1 wk, wkly x 4 wks, 2x month x 1 month, monthly x2 then quarterly with MDS schedule. Audit information will be compiled and forwarded to CQI for additional monitoring/modifications.  5. Completion on or before 8/23/13  F272		
F 272	483.20(b)(1) COMPREHENSIVE	F 272	1. Residents #2 and #3 have been assessed for safe individual mobility bar use.		

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F 272 SS=D	Continued From page 2 ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	<p>2. Any Resident with limited mobility is at risk for this practice.</p> <p>3. All Residents using mobility bars have been reassessed for safe individual use. All new admits will be assessed for safe individual use of mobility bars. Licensed nurses will be in-serviced on physical restraint assessment, for safe individual use of mobility devices at licensed nurse meeting 8/14/13.</p> <p>4. HIM or designee will audit new Resident's charts for assessment of safe individual use of mobility bar. All information will be compiled monthly and forwarded to CQI committee for additional monitoring/modifications.</p> <p>5. Completion date on or before 8/23/13</p>	
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F 272	<p>Continued From page 3</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 siderails were assessed as safe with individual resident use. This was true for 2 of 6 residents (#2 and #3) reviewed for siderail use. This failed practice placed the residents at risk for harm from entrapment in the siderails. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 1/21/13 with multiple diagnoses which included Alzheimer's Disease and generalized pain.</p> <p>The resident's most recent quarterly MDS assessment, dated 4/22/13, coded in part: * Severely impaired cognition; * Extensive assistance for bed mobility, transfers, toileting, and personal hygiene; * Lower extremity impairment on one side; and, * Frequent bowel/bladder incontinence.</p> <p>Resident #2 comprehensive care plan dated 4/25/13, identified the problem, "Alteration in mobility." One approach was, "Mobility bars to help facilitate positioning and transfers."</p> <p>On 7/15/13 at about 1:48 p.m., Resident #2 was not in her room. However, bilateral 1/8th siderails were observed in the raised position near the head of the resident's bed.</p> <p>On 7/16/13 from 3:05 p.m. to 3:30 p.m., Resident #2 was observed asleep on her bed with the bilateral 1/8th siderails in the raised position.</p> <p>Review of the resident's clinical record revealed</p>	F 272		
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F 272	<p>Continued From page 4</p> <p>there was no documentation that addressed whether or not the resident had been assessed to determine if she was safe with the use of the siderails.</p> <p>On 7/18/13 at about 2:45 p.m., the DON was asked if the resident had been assessed to determine if she was safe with the use of the siderails. The DON indicated she would check and get back to the surveyors.</p> <p>On 7/19/13 at about 10:55 a.m., the DON provided an Interdisciplinary Progress Note, dated 4/19/13, "Late entry," that documented, "MMRC [Mobility Medication Review Committee] met 4/18/13. Resident cont[inue]s to require bilat[eral] mobility bars to assist self [with] bed mobility." The DON indicated there were no other siderail assessments completed for Resident #2.</p> <p>2. Resident #3 was admitted to the facility on 3/28/11, and readmitted on 3/9/13, with multiple diagnoses which included gastrointestinal bleed, atrial fibrillation, and congestive heart failure.</p> <p>The resident's most recent quarterly MDS assessment, dated 6/4/13, coded in part:</p> <ul style="list-style-type: none"> <li>* Intact cognition, with a BIMS score of 13;</li> <li>* Limited assistance for bed mobility, transfers, toilet use, and personal hygiene;</li> <li>* Impaired functional ability in one upper and one lower extremity;</li> <li>* Occasional urinary incontinence; and,</li> <li>* Frequent bowel incontinence.</li> </ul> <p>Resident #3's comprehensive care plan, dated 6/6/13, included the problem, "Mobility impairment." One approach was, "Mobility bar to left side of bed to assist with transfers and bed</p>	F 272		
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F 272	Continued From page 5 mobility."  On 7/16/13 at 11:30 a.m., Resident #3 was observed in bed with a single 1/8th siderail in the raised position near the head of the bed on the left side.  On 7/16/13 at 5:20 p.m. and 7/17/13 at 9:10 a.m., the resident was observed sitting on the left side of the bed leaning against the 1/8th siderail, which was in the raised position.  On 7/17/13 at about 4:45 p.m., the resident was observed lying on the bed with the left 1/8th siderail in the raised position.  On 7/18/13 at about 2:45 p.m., the DON was asked if the resident had been assessed to determine if she was safe with the use of the siderails. The DON indicated she would check and get back to the surveyors.  On 7/19/13 at about 10:55 a.m., the DON provided a Daily Skilled Note, dated 4/18/13 at 5:00 p.m., that documented, "MMRC [Mobility Medication Review Committee] met. Resident using one mobility bar to assist [with] [independent] bed mobility. Cont[inue] as remains necessary." The DON indicated there were no other siderail assessments completed for Resident #3.	F 272			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or	F 280			

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F 280	<p>Continued From page 6 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 observation, interview, and record review, it was determined the facility did not ensure residents' comprehensive care plans were revised to include behavioral interventions, or interventions identified by the facility to reduce fall risk. This was true for 3 of 6 (R #s 1, 4, and 5) sampled for care plan revisions. The deficient practice had the potential to place residents at risk of more than minimal harm when it was not clear to the staff which interventions were currently in place to ensure resident safety. Findings included:</p> <p>1. Resident #5 was admitted to the facility on 4/29/13 with multiple diagnoses including possible cerebrovascular accident, transient ischemic attack, and alteration in mental status.</p> <p>Resident #5's Change of Condition MDS</p>	F 280	<p>F280</p> <p>1. For resident #5 care plan has been updated to include intervention of "Staff member observes Resident when he is outdoors in front of the building by himself. This intervention decreases his behavior". Resident #1 care plan has been updated for walker to remain in his room. #4 care plan has been updated and "1:1 visits when upset" has been removed.</p> <p>2. All Residents in the facility have the potential to be affected by this practice.</p> <p>3. All nurses were in-serviced 8/14/13 on comprehensive care plans and care planning. The IDP team was in-serviced on these same procedures 8/15/13.</p>	

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F 280	<p>Continued From page 7 assessment, dated 5/25/13, coded: -BIMS of 7, indicating severely impaired cognition. -Hallucinations and delusions present. -Physical behavioral symptoms directed towards others 1-3 days out of the past 7 days, placing the resident at risk of harming himself and interfering with his care. -Falls with fractures within the past 6 months, additional falls since admission to the facility.</p> <p>Resident # 5's CAAs related to the 5/25/13 MDS documented: -Cognitive loss, "Resident has short and long term memory deficits...he does not remember that he fell and fractured his [hip], or his hip precautions and will transfer and walk..." -Behaviors, "Resident has been verbally abusive and has struck out at caregivers. He can be more acutely confused with paranoia and fearfulness which seem to be a factor in times of aggressiveness..." -Falls, "...dementia, anxiety, and paranoia. Fall prior to hip fracture was most likely a related to these behaviors [sic]. He is at risk for falls at this time..."</p> <p>Resident #5's care plan, dated 7/11/13, documented: -Problem area, "Alteration in mobility...risk for falls." Approaches, "Resident has poor safety awareness. He forgets that he needs SBA [stand-by assist] to ambulate and will stand and walk without assist", and, "Resident likes to go outside in nice weather. Staff will observe for safety and SBA while outside of facility, engage in conversation during these times to distract from staff "following him." -Problem area, "High risk for violence directed at</p>	F 280	<p>4. DNS or designee will audit Resident care plans weekly for updates with the care conference schedule. Audits will be compiled and forwarded to CQI for additional monitoring/modification.</p> <p>5. Completion date on or before 8/23/13</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/19/2013
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F 280	<p>Continued From page 8</p> <p>others [related to]...paranoia state and hallucinations..." Approaches included, "Observe resident from a safe distance for both resident and staff during agitated episodes. Keep interactions to as few staff members as possible at these times..."</p> <p>[NOTE: Resident #5's care plan did not specify it was safe for Resident #5 to be outside unsupervised. The care plan did not include a Wanderguard alarm or auto-lock brakes to his wheelchair.]</p> <p>On 7/16/13 at 9:55 AM, Resident #5 was observed in the therapy gym in the facility. At 10:15 AM, Resident #5 was observed to remove himself from the therapy gym in his wheelchair, and propel himself towards the front door. The Wanderguard alarm sounded as Resident #5 exited the facility through the front door. The surveyor also went outside to continue observation of the resident. Resident #5 paused in the patio area just outside the front door of the facility, then at 10:22 AM began to propel himself down the west side of the horseshoe-shaped sidewalk. At the end of the horseshoe, Resident #5 turned right, propelled himself down a sidewalk connecting the two ends of the horseshoe-shaped sidewalk, and up the east side of the horseshoe towards the facility. At 10:30 AM, Resident #5 returned to the front door of the facility but continued to remain outside. During this time, no staff had been observed to provide stand-by assistance to Resident #5.</p> <p>On 7/16/13 at 10:35 AM, OT #5 approached Resident #5 as he sat outside, and offered to assist him inside. OT #5 was asked if Resident #5 should have been outside without supervision. OT #5 stated, "It's OK for [Resident #5] to be</p>	F 280		
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F 280	<p>Continued From page 9</p> <p>outside alone, because of increased agitation when he thinks he's being followed. It helps because he worked for the Forest Service for 40 years." [NOTE: Resident #5's care plan did direct staff to attempt to engage him in conversation about his Forest Service career.] OT #5 stated Resident #5 was assisted outside either per his request, or when the Wanderguard alarm alerted staff he wanted to go outside. OT #5 stated during business hours, whoever assisted Resident #5 outside would alert the receptionist, who could watch Resident #5 through the window from her work station. OT #5 stated the facility had noted a decrease in Resident #5's agitation with this plan.</p> <p>On 7/16/13 at 2:00 PM, the DNS was asked about the surveyor's observations that morning. The DNS stated when Resident #5 was allowed outside by himself, it decreased his agitation, and there had been no problems with the receptionist providing supervision at these times. The DNS was asked if this intervention was on Resident #5's care plan. The DNS stated, "I'll have to look."</p> <p>On 7/17/13 at 5:15 PM, the Administrator and DNS were informed of these concerns. The facility offered no further information.</p> <p>2. Resident #1 was admitted to the facility on 3/1/12 with diagnoses which included CHF, hip joint replacement, and anemia.</p> <p>Resident #1's Quarterly MDS assessment, dated 7/2/13, coded: -BIMS of 15, indicating Resident #1 was cognitively intact. -Extensive assistance of 1 person required for transfers.</p>	F 280		
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F 280	<p>Continued From page 10</p> <p>-Supervision from one person for ambulation. -No falls since previous MDS assessment.</p> <p>Resident #1's care plan, dated 7/5/13, documented, "Alteration in mobility [related to fracture] of right hip...risk for falls..." Approaches included, "Walker stored in therapy room not residents [sic] room to prevent attempts to ambulate independently."</p> <p>[NOTE: Resident #1 had a remote history of a fall with a hip fracture, long before his admission to the facility. Resident #1 did have a fall in the facility, with a hip fracture, following a pacemaker malfunction on 3/27/13.]</p> <p>Resident #1 was interviewed on 7/16/13 at 9:30 AM. During the interview, Resident #1 stated that he had heart problems which caused dizzy spells, and that twice in the past he had fallen and broken each of his hips. Resident #1 stated, "I have to have someone with me now when I'm walking. That's the rule."</p> <p>Resident #1's four-wheeled walker was observed to be stored in his room on 7/16/13 at 9:20 AM, 1:10 PM, and 5:00 PM; and again on 7/17/13 at 7:15 AM.</p> <p>On 7/17/13 at 12:15 PM, the DNS was interviewed about Resident #1's care plan approach to store his walker in the therapy room. The DNS stated, "I know. I have that highlighted on my copy of his care plan as well. We'll have to fix that."</p> <p>On 7/17/13 at 5:15 PM, the Administrator and DNS were informed of these concerns. The facility offered no further information.</p>	F 280			

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F 280	<p>Continued From page 11</p> <p>3. Resident #4 was admitted to the facility on 4/4/11, and readmitted on 8/4/12, with multiple diagnoses which included agitation, senile dementia, and depressive disorder.</p> <p>The resident's most recent significant change MDS assessment, dated 4/23/13, coded in part:</p> <ul style="list-style-type: none"> <li>* Severely impaired cognition with BIMS score of 4;</li> <li>* Extensive assistance of 1 person for bed mobility, transfers, ambulation in the resident's room/hallways and on/off the unit;</li> <li>* Worsened behavior;</li> <li>* Wandering occurred 1-3 days during the look back period; and,</li> <li>* The wandering placed the resident at significant risk for getting to a potential dangerous place and significant intrusion on others' privacy.</li> </ul> <p>On 6/7/13 and 7/3/13, the Bureau of Facility Standards (BFS) received letters and information from the facility that Resident #4 was involved in altercations with other residents on 6/1/13 and 6/26/13.</p> <p>The letters/information included the following documentation:</p> <ul style="list-style-type: none"> <li>* 6/1/13 - Resident #4 slapped another resident's hand 3 times. Interventions implemented at that time included stimulating tasks, 1:1 "visits" when increased agitation with other residents was noted.</li> <li>* 6/26/13 - Resident #4 struck another resident's shoulder with her fist. Interventions implemented at that time included stimulating tasks, 1:1 visits during waking hours, and 15 minute checks while</li> </ul>	F 280		

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F 280	<p>Continued From page 12 asleep.</p> <p>The resident's comprehensive care plan dated 5/2/13, identified the problem, "High risk for violence directed at others..." Plans and approaches included, "...(2) Provide 1:1 visits when upset [with] other Residents. (3) Does not interact well [with] other demented Residents: intervene as often as possible... (5) believes other male residents are deceased husband - redirect immediately as this causes discomfort for both Resident [and] other Resident..."</p> <p>On 6/26/13, additional approaches were added to the aforementioned care plan as follows, "1:1 at all times when awake[.] Discourage Resident from sitting on couch with other residents[.] Q [every] 15 min[ute] [check] when in bed."</p> <p>Note: On 6/26/13, when the 1:1 supervision was increased, the "1:1 visits when upset with other residents" was not removed from the care plan. Having two different interventions for 1:1 supervision created the potential for staff to be confused on which intervention to follow.</p> <p>On 7/18/13 at 10:45 a.m., when asked about the 2 different approaches for 1:1 supervision for Resident #4, the DON stated the 1:1 visits when the resident was upset with other residents should have been removed from the care plan.</p> <p>On 7/18/13 at 3:30 p.m., the Administrator was also informed of the care plan revision issue. No other information was received from the facility which resolved the issue.</p>	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 13  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.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility did not ensure residents receiving Coumadin received PT/INR checks per physician's orders. Additionally, the facility did not ensure a resident with dementia was monitored for behavioral changes following the death of her husband, nor did they ensure desired outcomes were identified and monitored as she expressed her grief and distress. This was true for 3 of 6 Residents (#s 1, 3, and 4) sampled for Coumadin use and behavior monitoring. The deficient practice had the potential to cause more than minimal harm if residents experienced bruising or bleeding from Coumadin use, and when a resident began to strike out against other residents following the death of her husband. Findings included:  1. Resident #1 was admitted to the facility on 3/1/12 with diagnoses which included CHF, hip joint replacement, anemia, and atrial fibrillation.  Resident #1's Physician's Orders for July 2013 documented the resident received Coumadin for atrial fibrillation, with his most recent dosage change on 5/29/13.	F 309	F309  1. Resident #1 and 3's most recent PT/INR labs are on their charts. Resident #4 behaviors are being monitored via electronic documentation and q shift behavior documentation.  2. All residents having labs drawn for PT/INR are at risk for this practice. All Residents exhibiting behaviors are at risk for this practice.  3. Anticoagulant/lab therapy record has been initiated for all Residents receiving Coumadin. All Nurses have been educated on it's use at nurses meeting 8/14/13. All nurses have been educated on q behavior shift doc All staff were reeducated on electronic behavior documentation at the all staff meeting 8/14/13.	

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F 309	<p>Continued From page 14</p> <p>On 5/29/13, laboratory results in Resident #1's record documented a PT/INR of 20.6 and 1.8, respectively. Resident #5's physician documented on this form Resident #5's Coumadin dose should be changed to 7.5 mg 6 days per week and 5 mg 1 day per week, with Resident #5's PT/INR to be re-checked in two weeks (6/12/13).</p> <p>On 7/3/13, laboratory results in Resident #1's record documented a PT/INR of 30.3 and 2.7, respectively. [NOTE: 20 days had elapsed since the PT/INR was due to be drawn.] Resident #5's physician documented the current dose of Coumadin should be continued, and re-checked in 2 weeks.</p> <p>On 7/17/13 at 8:30 AM, the DNS was asked about the PT/INR scheduled to be drawn as ordered 2 weeks after 5/29/13. The DNS stated, "We don't have it. We've called the cardiologist and everything." The surveyor requested to see the facility's policy and procedure for Coumadin management. On 7/17/13 at 10:50 AM, the DNS returned and stated, "We don't have one. Coumadin management is driven individually by the resident's physicians."</p> <p>On 7/17/13 at 5:15 PM, the Administrator and DNS were informed of the surveyor's concerns. The facility offered no further information.</p> <p>2. Resident #4 was admitted to the facility on 4/4/11, and readmitted on 8/4/12, with multiple diagnoses which included agitation, senile dementia, and depressive disorder.</p> <p>The resident's most recent significant change</p>	F 309	<p>4. DNS or designee will audit anticoagulant labs weekly x 4 weeks, monthly x 2. Audits will be compiled and information forwarded to CQI for any additional monitoring modification.</p> <p>SSD or designee will audit behavior documentation weekly x2 weeks, bi-weekly x 4 wks and monthly x3 thereafter. Audits will be compiled and information forwarded to CQI for additional monitoring/modification.</p> <p>5. Completion date on or before 8/23/13</p>		

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F 309	<p>Continued From page 15</p> <p>MDS assessment, dated 4/23/13, coded in part:</p> <ul style="list-style-type: none"> <li>* Severely impaired cognition with a BIMS score of 4;</li> <li>* Extensive assistance of 1 person for bed mobility, transfers, ambulation in the resident's room/hallways and on/off the unit;</li> <li>* Worsened behavior;</li> <li>* Wandering occurred 1-3 days during the look back period; and,</li> <li>* Wandering placed the resident at significant risk for getting to a potentially dangerous place and significant intrusion on others' privacy.</li> </ul> <p>The resident's comprehensive care plan, dated 5/2/13, included the following problems and approaches:</p> <ul style="list-style-type: none"> <li>* Altered thought process - "Monitor behavior and orientation. Monitor room for other residents belongings and return...if resident is looking for spouse. If resident showing grief response validate feelings, provide support and comfort."</li> <li>* Poor individual coping - "Monitor grief response r/t [related to] death of spouse...irritability with other confused residents...restlessness or anxiousness...fearfulness...do not discount delusional thinking..."</li> </ul> <p>On 6/7/13 and 7/3/13, the Bureau of Facility Standards (BFS) received letters and information from the facility that Resident #4 was involved in altercations with other residents on 6/1/13 and 6/26/13. The letters/information included the following:</p> <ul style="list-style-type: none"> <li>* 6/1/13 - Resident #4 slapped another resident's hand 3 times. Interventions implemented at that time included stimulating tasks, 1:1 "visits" when increased agitation with other residents was noted.</li> <li>* 6/26/13 - Resident #4 struck another resident's</li> </ul>	F 309		

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F 309	<p>Continued From page 16</p> <p>shoulder with her fist. Interventions implemented at that time included stimulating tasks, 1:1 visits during waking hours, and 15 minute checks while asleep.</p> <p>Review of the resident's clinical record revealed there was no documentation that the aforementioned behaviors were monitored.</p> <p>On 7/18/13 at 10:45 a.m., the DON was asked if Resident #4's identified behaviors were monitored. The DON said the behaviors were monitored and she would review the resident's clinical record for the documentation then get back with the surveyor.</p> <p>On 7/18/13 at about 3:00 p.m., the DON stated she did not find any behavior monitors documented for Resident #4.</p> <p>On 7/18/13 at 3:30 p.m., the Administrator was also informed of the behavior monitor issue. No other information or documentation was received from the facility that resolved the issue.</p> <p>3. Resident #3 was admitted to the facility on 3/28/11, and readmitted on 3/9/13, with multiple diagnoses which included atrial fibrillation.</p> <p>Resident #3's recapitulation (recap) of Physician's Orders for July 2013 documented Coumadin (a blood thinner) was ordered for atrial fibrillation. The recap also included an order for a PT/INR (a lab test to monitor how much Coumadin was/was not needed) on 7/10/13.</p> <p>Review of the resident's clinical record revealed a PT/INR report, dated 6/12/13, with the hand written order, "Cont[inue] same re[check] INR 1</p>	F 309			

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F 309	Continued From page 17 mo[nth]. " However, there were no PT/INR reports for July 2013 found in the resident's record.  On 7/18/13 at about 2:00 p.m., when asked about Resident #3's PT/INR ordered for 7/10/13, the DNS said she would research it and get back with the surveyor.  About 20 minutes later, the DNS stated the PT/INR had not been done. She added that a PT/INR would be done that day. No other information was received from the facility that resolved the issue.	F 309			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to provide adequate supervision for 1 of 6 sample residents (#4). Failure to implement 1 to 1 supervision for Resident #4, as care planned, placed the resident and other residents at risk for injury related to resident to resident altercations. Findings included:  Resident #4 was admitted to the facility on 4/4/11,	F 323	F323  1. Resident #4 has a staff member individually assigned to this Resident for the purpose of supervision of behavior management. Care plan has been updated.  2. Any Resident needing supervision for behavior management is at risk for this practice.  3. All staff members were in serviced at all staff meeting on behavioral supervision 8/12/12.		

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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST 7TH STREET SILVERTON, ID 83867		
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F 323	<p>Continued From page 18 and readmitted on 8/4/12, with multiple diagnoses which included agitation, senile dementia, and depressive disorder.</p> <p>The resident's most recent significant change MDS assessment, dated 4/23/13, coded in part: * Severely impaired cognition with BIMS score of 4; * Extensive assistance of 1 person for bed mobility, transfers, ambulation in the resident's room/hallways and on/off the unit; * Worsened behavior; * Wandering occurred 1-3 days during the look back period; and, * The wandering placed the resident at significant risk for getting to a potential dangerous place and significant intrusion on others' privacy.</p> <p>On 6/7/13 and 7/3/13, the Bureau of Facility Standards (BFS) received letters and information from the facility that Resident #4 was involved in altercations with other residents on 6/1/13 and 6/26/13. The letters/information documented the following: * 6/1/13 - Resident #4 slapped another resident's hand 3 times. Interventions implemented at that time included stimulating tasks, 1:1 "visits" when increased agitation with other residents was noted. * 6/26/13 - Resident #4 struck another resident's shoulder with her fist. Interventions implemented at that time included stimulating tasks, 1:1 visits during waking hours, and 15 minute checks while asleep.</p> <p>The resident's comprehensive care plan dated 5/2/13, identified the problem, "High risk for violence directed at others..." Plans and approaches included, "...(2) Provide 1:1 visits</p>	F 323	<p>4. Administrator or designee will monitor behavior supervision assignments daily x 1 wk, weekly x 4, bi-weekly x2 then monthly. Audit information will be compiled and forwarded to CQI for additional monitoring/modification.</p> <p>5. Completion date on or before 8/23/13</p>	

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F 323	<p>Continued From page 19</p> <p>when upset [with] other Residents. (3) Does not interact well [with] other demented Residents: intervene as often as possible... (5) believes other male residents are deceased husband - redirect immediately as this causes discomfort for both Resident [and] other Resident..."</p> <p>On 6/26/13, additional care plan approaches were, "1:1 at all times when awake[.] Discourage Resident from sitting on couch with other residents[.] Q 15 min when in bed [Every 15 minute checks when in bed]."</p> <p>Note: On 6/26/13, when the 1:1 supervision was increased, the "1:1 visits when upset with other residents" was not removed from the care plan. Refer to F280 regarding care plan revision.</p> <p>On 7/17/13 from 7:05 a.m. to 7:48 a.m., Resident #4 was observed seated alone at a table in the dining room eating breakfast. During this time, from 2-5 staff were observed assisting and/or interacting with other residents in the dining room; however, none of the staff sat with or interacted with Resident #4. Resident #4 was left alone at the dining table for 43 minutes.</p> <p>At 7:48 a.m., the Medical Records Supervisor (MRS) briefly spoke to Resident #4, who was still seated alone at the dining table. Then, the MRS assisted another resident out of the dining room.</p> <p>From 7:48 a.m. to 7:54 a.m., Resident #4 remained alone at the dining table. At 7:54 a.m., the MRS returned to the dining room and assisted Resident #4 to ambulate out of the dining room, down the hall, and to the common area between the nurses station and the lounge. In the common area, the resident sat alone on the loveseat by the aquarium while the MRS crossed the room to</p>	F 323			

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F 323	<p>Continued From page 20</p> <p>assist another resident. Resident #4 was again left alone for 6 minutes.</p> <p>At 7:58 a.m., the MRS asked the MDS nurse to assist her with the residents in the common area. At that point, the MRS assisted another resident out of the area and the MDS nurse went around talking to other residents in the area. At 8:05 a.m., the MDS nurse sat next to Resident #4 on the loveseat. Resident #4 was alone on the loveseat for 7 minutes before any staff provided 1:1 supervision.</p> <p>On 7/18/13 at 10:45 a.m., the DON was interviewed. When asked how 1:1 staff were assigned to Resident #4, the DON stated, "No one staff is assigned as 1:1." When asked for the facility's policy regarding 1:1 supervision, the DON stated there was no such policy. When asked how staff know what 1:1 means, the DON stated, "To us that means to be available in seconds." When asked if the staff are to provide care for other residents while they are providing 1:1 supervision for Resident #4, the DON stated, "No." At this time, the DON was informed of the multiple observations of Resident #4 without 1:1 supervision when she was not in her room.</p> <p>The facility failed to provide adequate 1:1 supervision for Resident #4 which placed the resident, as well as other residents at risk for injury should additional altercations between residents occur.</p> <p>On 7/18/13 at 3:30 p.m., the Administrator was also informed of the 1:1 supervision issue regarding Resident #4. However, no other information or documentation was received from the facility that resolved the issue.</p>	F 323		

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F 329 SS=E	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility did not provide adequate monitoring to ensure residents were free from unnecessary drugs. This was true for 4 of 4 residents (#s 5, 6, 7, and 8) sampled for monitoring behaviors related to psychotropic medication use. The deficient practice had the potential to cause more than minimal harm if the residents receiving anti-psychotic medications</p>	F 329	<p>F329</p> <ol style="list-style-type: none"> <li>1. Resident's #5,6,7,8 reviewed for antipsychotic medications. Care plans have been updated to reflect individualized interventions for targeted behaviors.</li> <li>2. Any Resident receiving anti-psychotic medications are at risk for this practice.</li> <li>3. In service on anti psychotic medications and reduction attempts, behavioral causes and interventions was completed 8/14/13 at behavior committee. In service on electronic behavior documentation was completed at all staff meeting 8/14/13. Nurses were in serviced on anti psychotic medications and reduction attempts, behavioral causes and interventions was completed 8/14/13.</li> </ol>	

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F 329	<p>Continued From page 22</p> <p>experienced negative side effects without monitoring for the true effectiveness for the individual resident. Findings included:</p> <p>Federal Guidance at F 329, specifically regarding the use of anti-psychotic medications in elderly residents, documented, "Before initiating or increasing an antipsychotic medication for enduring conditions, the target behavior must be clearly and specifically identified and documented. Monitoring must ensure that the behavioral symptoms are...not due to a medical condition or problem...and not due to environmental stressors alone...and not due to psychological stressors alone...and persistent...when dosing an antipsychotic, the treatment should be at the lowest possible dose to improve the target symptoms being monitored... when monitoring antipsychotics, it is important to not only evaluate ongoing effectiveness and potential adverse consequences...after initiating or increasing the dose of an antipsychotic medication, the behavioral symptoms must be evaluated periodically...to determine the effectiveness of the antipsychotic and the potential for reducing or discontinuing the dose based on target symptoms..."</p> <p>[NOTE: Please see interviews with DNS regarding behavior monitoring after all of the resident examples.]</p> <p>1. Resident #6 was admitted to the facility on 6/2/06 with multiple diagnoses including dementia with delirium. Resident #6's Discharge Summary from the acute care hospital, dated 6/2/06, documented, "Patient has problems with minimal confusion but more significantly hallucinations of</p>	F 329	<p>4. SSD/DNS or designees will audit behavior documentation, medication dosing and monitoring of side effects weekly x 2, bi-weekly x 1 month, monthly x3. Information will be compiled and forwarded to CQI for additional monitoring/modifications.</p> <p>5. Completion date on or before 8/23/13</p>		

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F 329	<p>Continued From page 23 the auditory type while in the hospital..."</p> <p>Resident #6's most recent Quarterly MDS assessment, dated 5/14/13, coded: -BIMS of 6, indicating severely impaired cognition -No hallucinations or delusions. -No other behavioral symptoms noted.</p> <p>Resident #6's Physician's Orders for July 2013 (Recapitulation Orders) documented Resident #6 received Zyprexa 5 mg daily for a diagnosis of Alzheimer's Dementia with Hallucinations, ordered 3/5/13.</p> <p>Resident #6's care plan regarding the use of Zyprexa, dated 5/16/13, documented, "Dose reduction attempted 4/4/09 - Failed Dose Reduction 4/21/09. Drug Holiday 12/10 - 12-15/09 - Failed. 11/29/11 - Failed."</p> <p>Resident #6's Mood &amp; Behavior Report from 5/1/13 - 7/17/13 documented Resident #6 was short-tempered and easily annoyed and had verbal behavioral symptoms directed towards others on 6/29/13. No other mood or behavior indicators were recorded.</p> <p>On 7/17/13 at 11:50 AM, the SSD was interviewed regarding the behavioral history for Resident #5. The SSD stated Resident #5 had a long-standing history of using anti-psychotic medication, and that previous attempts at decreasing the dose had resulted in "increased belligerence" and that Resident #5 would stop eating. When asked if those specific target behaviors were being monitored for Resident #5, the SSD stated they were not.</p> <p>2. Resident #5 was admitted to the facility on</p>	F 329		

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F 329	<p>Continued From page 24</p> <p>4/29/13 with multiple diagnoses including possible cerebrovascular accident, transient ischemic attack, and alteration in mental status.</p> <p>Resident #5's Change of Condition MDS assessment, dated 5/25/13, coded: -BIMS of 7, indicating severely impaired cognition. -Hallucinations and delusions present. -Physical behavioral symptoms directed towards others 1-3 days out of the past 7 days, placing the resident at risk of harming himself and interfering with his care.</p> <p>Resident #5's Behavioral Symptoms CAA, dated 5/31/13, documented, "Resident has been verbally abusive and has struck out at caregivers. He can be more acutely confused with paranoia and fearfulness which seems to be a factor in times of aggressiveness. He has shown a very quick temper from his original admit, again when he does not seem to comprehend where he is and why..."</p> <p>Resident #5's Mood and Behavior Report, beginning 5/1/13, documented: -Mood of "Being short-tempered, easily annoyed" on 5/5/13, 5/14/13, 5/20/13, 6/10/13, 7/11/13, and 7/16/13. -Behavior of, "Rejection of Care" on 5/5/13, 6/10/13, 7/11/13, and 7/16/13. -Behavior of, "Physical behavioral symptoms directed towards others" on 5/14/13, 5/20/13, 6/10/13, and 7/16/13. -Behavior of, "Verbal behavioral symptoms directed towards others" on 6/10/13, 7/11/13, and 7/16/13. -Behavior of, "Other behavioral symptoms directed towards others" on 6/10/13, 7/10/13,</p>	F 329			

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F 329	<p>Continued From page 25 7/11/13, and 7/16/13.</p> <p>On 7/9/13, a facility "Fax to Communication to Physician" form documented, "Res[ident] is having increase in hallucinations, delusions, and paranoia. Sat[urday] 7/6 [2013] was kicking at doors and being physically assaultive [with] staff..." The "Response by Physician" area of that form documented Resident #5 was to begin receiving Zyprexa 2.5 mg twice daily beginning 7/10/13, for a diagnosis of paranoid state with delusions and hallucinations.</p> <p>3. Resident #7 was admitted to the facility on 9/15/11 with multiple diagnoses which included generalized anxiety disorder.</p> <p>Resident #7's MAR for July 2013 documented Resident #7 was receiving Saphris (an atypical antipsychotic medication) 5 mg twice per day, starting 5/9/13.</p> <p>Resident #7's Mood and Behavior Report from 5/1/13 through 7/18/13 documented: -5/7/13, "Other behavioral symptoms not directed towards others." -5/8/13, "Being short-tempered and easily annoyed", "Trouble falling or staying asleep or sleeping too much, "Physical Behavioral symptoms directed towards others", and "Verbal behavioral symptoms directed towards others." -6/13/13, "Other behavioral symptoms directed towards others.</p> <p>On 7/4/13, Resident #7's Interdisciplinary Assessments and Summary Reviews documented, "[Resident #7] remains on Saphris and Ativan for generalized anxiety and psychosis...she did not do well with [decrease in]</p>	F 329		
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F 329	<p>Continued From page 26</p> <p>Saphris, as delusional thinking resurfaced..."</p> <p>4. Resident #8 was admitted to the facility on 12/1/11 with multiple diagnoses including senile dementia and insomnia.</p> <p>Resident #8's Quarterly MDS assessment, dated 7/16/13, coded: -BIMS of 3, indicating severely impaired cognition. -No mood concerns. -No hallucinations or delusions, no behaviors impacting Resident #8 or others.</p> <p>Resident #8's Recapitulation Orders for July 2013 documented Resident #8 received Seroquel 25 mg twice per day, beginning 10/3/12.</p> <p>Resident #8's Mood and Behavior Report for 5/1/13 through 7/18/13 documented, "No data found that matches report selections. End of report."</p> <p>On 7/17/13 at 8:30 AM, the DNS was interviewed about behavior tracking for anti-psychotic use for Resident #s 5 and #6. The DNS stated in general, behaviors were charted by exception, only if a behavior occurred for that resident on that shift. The DNS stated all of the data on resident Mood and Behavior reports was entered by the CNAs caring for the resident on that shift. The DNS described the behavior tracking system as follows: There were no specific target behaviors identified for the use of a specific medication or for specific residents. If the CNA caring for any resident on any shift "thought" a "behavior" occurred, they could select "Mood/Behavior" in the resident's electronic record when charting ADLs. Once the CNA had selected that option, a</p>	F 329			

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F 329	<p>Continued From page 27</p> <p>"drop-down" menu appeared and offered a set of pre-determined, generic mood and behavioral choices. The CNA then selected from a menu of generic options for interventions they tried to use. There was also a small space for the CNA to write a brief narrative on whether or not the interventions were effective. [NOTE: There was no requirement for the LN to assess and monitor resident behaviors, even when the resident was receiving a medication specifically for behavioral issues. The facility behavioral documentation did not include nursing assessments to identify possible medical, environmental, or psychosocial aspects of behavioral issues.]</p> <p>On 7/18/13, the DNS was asked about behavior tracking for Resident # 7 and Resident #8. The DNS stated the same system was used to track behaviors for those residents as for Resident #s 5 and 6, and no further specific information was available.</p> <p>The DNS was unable to identify how, before beginning or increasing anti-psychotic medications, the facility consistently identified or documented specific target behaviors. Once an anti-psychotic medication was initiated, the DNS was unable to identify how target behaviors were monitored for persistence, how the effectiveness of the medications was monitored in terms of treating the target symptoms, or how potential negative consequences of the medications were evaluated. Other than the information in the above interview, the facility did not demonstrate the evaluation of potential underlying medical, environmental, or psychological stressors related to the use of anti-psychotic medications. The facility was also unable to demonstrate they had been able to re-evaluate anti-psychotic</p>	F 329		
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F 329	Continued From page 28 medications were being used at the lowest possible dose, based on specific target behavioral symptoms.	F 329		
F 332 SS=D	<p>On 7/18/13 at 3:30 PM, the Administrator and the DNS were informed of the surveyor's findings. The facility offered no further information.</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure it maintained a medication error rate less than 5 percent. This was true for 5 of 29 medications (17 percent) during medication pass observations which affected 2 of 6 resident (#2 and #6). This failure created the potential for the affected residents to receive less than optimum benefit from prescribed medication. Findings included:</p> <p>1. Resident #6's recapitulation (recap) of Physician's Orders for July 2013 included an order for Miralax 1 cap by mouth every day in water or juice.</p> <p>On 7/16/13 at 9:40 a.m., LN #3 was observed as she poured, then administered 9 oral medications, including MiraLax 17 grams (gm) which was mixed in approximately 90 milliliters (ml) of water, to Resident #6.</p>	F 332	<p>F332</p> <ol style="list-style-type: none"> <li>Residents #2&amp;6 Miralax orders have been changed to include "mix with 4-8oz of fluid. Resident #2 Toviaz and Omeprazole have been d/cd. Resident #2 levothyroxine is scheduled to be given at 0600.</li> <li>Any Resident receiving Miralax, Levothyroxine, Omeprazole or Toviaz have the potential to be affected by this practice.</li> </ol>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/19/2013
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST 7TH STREET SILVERTON, ID 83867
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F 332	<p>Continued From page 29</p> <p>Regarding MiraLax, the Nursing 2013 Drug Handbook states under the Oral Administration and Patient Teaching sections, "Dissolve powder in 8 ounces (240 ml) of water, juice, soda, coffee, or tea." Note: The directions on the MiraLax bottle itself instructed to mix 17 gms of MiraLax with 4-8 ounces (oz) of liquid.</p> <p>The LN did not mix the MiraLax in a sufficient amount of liquid.</p> <p>On 7/18/13 at 3:30 p.m., the Administrator and DON were informed of the medication error.</p> <p>2. Resident #2's recapitulation (recap) of Physician's Orders for July 2013 included:          * "May crush all medications (resident will not take meds unless crushed);"          * Toviaz 4 milligrams (mg) by mouth (PO) every day;          * Levothyroxine 112 micrograms (mcg) PO every day;          * Omeprazole 20 mg PO every day "on an empty stomach;" and,          * MiraLax 1 cap PO every day.</p> <p>On 7/18/13 at 9:20 a.m., LN #3 was observed as she poured 4 oral medications, one ear drop solution, and a supplemental drink for Resident #2.</p> <p>The oral medications (meds) included Toviaz ER [Extended Release], levothyroxine, MiraLax, and an omeprazole delayed release capsule. LN #3 crushed the Toviaz ER and levothyroxine and put them in a medicine cup with applesauce. The LN placed a whole capsule of the omeprazole in the same medicine cup with the 2 crushed</p>	F 332	<p>3. All nurses have been in serviced on proper amt of fluid to mix with Miralax, medications that cannot be crushed and dosing schedule for levothyroxine at nurses meeting 8/14/13.</p> <p>4. DNS or designee will audit med pass to ensure proper amount of fluid used with Miralax and levothyroxine is administered at the correct time 1xwk x 4, biweekly x 1 month and monthly x3. Audits will be compiled with finding forwarded to CQI for monitoring/modification.</p> <p>5. Completion on or before date 8/23/13.</p>	
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F 332	<p>Continued From page 30</p> <p>medications and applesauce. The LN stated she left the omeprazole whole because it was a delayed release capsule. The LN mixed MiraLax 17 gms in approximately 100 milliliters (ml) of water in a small plastic cup. The LN took all of the medications to Resident #2 and attempted to administer them to the resident. However, despite repeated encouragement by the LN, the resident refused all of the medications.</p> <p>Immediately afterward, LN #3 confirmed that she would have administered the medications had Resident #2 not refused them. When asked if the resident had eaten breakfast that morning, the LN stated, "Yes but I don't know when." When asked how many ounces of water she used to mix the MiraLax, the LN stated, "Eight ounces." However, when LN #3 poured water into an identical cup to demonstrate the amount of water she had used to mix the MiraLax, she acknowledged she used "Only 100 ml" of water.</p> <p>On 7/18/13 at 9:55 a.m., when asked, CNA #4 stated Resident #2 ate breakfast at about 7:00 a.m. that morning.</p> <p>The Nursing 2013 Drug Handbook states: * Levothyroxine - Oral Administration: "Give drug at same time on each day on an empty stomach, preferably 1/2 to 1 hour before breakfast." Patient Teaching: "...Take drug at same time each morning preferably 1/2 to 1 hour before breakfast, to maintain constant hormone levels and help prevent insomnia." * Omeprazole - Oral Administration: "Give drug at least 1 hour before meals." * Toviaz - Oral Administration: "Don't divide or crush tablets. Give with water and have patient swallow whole." Patient Teaching: "Tell patient to</p>	F 332			

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F 332	Continued From page 31 take pill with water and to swallow tablet whole. Tell him not to chew, crush, or divide tablet." * MiraLax - Oral Administration and Patient Teaching: "Dissolve powder in 8 ounces (240 ml) of water, juice, soda, coffee, or tea." Note: The directions on the MiraLax bottle instructed to mix 17 gms with 4-8 ounces (oz) of liquid.  The medication errors occurred when levothyroxine and omeprazole were both given after the meal, Toviaz ER was crushed rather than given whole, and when the MiraLax was mixed in an inadequate amount of liquid.  On 7/18/13 at 3:30 p.m., the Administrator and DON were informed of the medication errors.  On 7/19/13 at about 10:50 a.m., the DON referenced Toviaz and asked if the physician's order to "Crush all meds" was sufficient. However, when asked if the Physician had provided a rationale to crush Toviaz, the DON indicated there was not. No other information or documentation was received from the facility which resolved the medication error issues.	F 332			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371  1. Toaster and food processor were cleaned Scratched scoop plates were disposed of and replaced with new ones		

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F 371	<p>Continued From page 32</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure food was prepared and served under sanitary conditions. This had the potential to affect 9 of 9 sample residents (#s 1-9) and any other residents who ate from scoop plates, or ate food prepared using the food processor or toaster. This practice created the potential for cross-contamination of food and exposed residents to potential sources of pathogens. Findings included:</p> <p>On 7/15/13 at approximately 1:20 p.m., during the initial tour of the kitchen with the Dietary Manager (DM) in attendance, the following was observed: * A layer of fine crumbs on the metal plate behind the bread rack and crumbs collected in the corners on the tray at the bottom of the large toaster; and, * Small orange and white specks on the airvents on both sides of the food processor.</p> <p>The Dietary Manager confirmed the toaster had been used for breakfast that morning. She stated, "It should have been wiped out after breakfast." Regarding the food processor, the DM acknowledged the specks on the food processor airvents. She stated both the toaster and the food processor would be cleaned that day.</p> <p>On 7/16/13 at approximately 10:30 a.m., the large toaster and the food processor were observed to be clean.</p> <p>On 7/17/13 at 12:10 p.m., 8 of 16 scoop plates were observed with scratches on the bottom</p>	F 371	<p>2. All Residents have the potential to be affected by this practice.</p> <p>3. Education has been provided to the dietary staff on proper cleaning of the food processor and toaster and the need to remove scratched scoop plates from use on 8/23/13.</p> <p>4. Dietary manager or designee will audit cleaning of the toaster and food processor weekly x 4 weeks, 2 x month x 1 month, monthly x 3 months. Information obtained from audits will be compiled and forwarded to CQI for monitoring/modification.</p> <p>Dietary manager or designee will audit scoop plate condition weekly x 4 weeks, 2x month x 1 month and monthly x3 months. Information obtained from audits will be compiled and forwarded to CQI for monitoring/modification.</p>	

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F 371	Continued From page 33 inside surface. The DM, who was present at the time removed the 8 scratched scoop plates from service and stated she had more in her office. A few minutes later, the DM brought 5 new scoop plates into the kitchen.	F 371	5. Completion on or before 8/23/13		
F 431 SS=E	On 7/18/13 at 3:30 p.m., the Administrator and DON were informed of the kitchen issues. No other information was received from the facility. 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431	F431  1. Procedure for disposal of Fentanyl patches has been updated to include 2 licensed staff to witness disposal of patches.  Multi use vial of Tubersol and pneumovax were disposed of.  Lids have been added to the trash cans on the medication and treatment carts.		

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F 431	<p>Continued From page 34</p> <p>Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and policy review, it was determined the facility failed to ensure the disposal of used fentanyl (a controlled medication) patches was witnessed by 2 licensed nurses (LNs); all medications were in locked compartments; and, opened, time sensitive multidose medications were not available for resident use after 28 days. This was true for 1 sample resident (#2) and 1 random resident (#12) during medication pass observations, and 1 of 1 medication refrigerators. The failed practices created the potential for diversion of Resident #12's used fentanyl patches; possible contamination of opened vials of Tubersol and Pneumovax, which could affect any resident who needed to be screened for tuberculosis (TB) or who needed a pneumonia vaccination; and, possibly adverse effects for any independently mobile resident who may remove Resident #2's discarded medications from the medication trash can and ingest them. Findings included:</p> <p>1. Note: Informational Letter, Reference: S&amp;C: 13-02 NH, stated, in part, "Fentanyl transdermal patches are a controlled substance commonly used in nursing homes for pain medication. These patches present a unique situation given the multiple boxed warnings, the potential for</p>	F 431	<p>2. All residents who receive medications are at risk for this practice.</p> <p>3. In service on medication disposal including fentanyl patch destruction and documentation on multiuse vials was completed 8/14/13.</p>	

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F 431	<p>Continued From page 35</p> <p>abuse, misuse and diversion, and the substantial amount of fentanyl remaining in the patch after use. The facility's policies must address safe and secure storage, limited access and reconciliation of controlled substances in order to minimize loss or diversion, and provide for safe handling, distribution and disposition of the medications. One benefit of the patch is the continuous delivery of fentanyl over 72 hours. This slow-release of fentanyl from the transdermal reservoir allows for more consistent pain control in patients with chronic pain. This unique delivery system, however, is not impervious to diversion, even after the fentanyl patch has been used, removed and/or disposed. One study determined that even after three days of use, 28 to 84.4% of the original fentanyl dose was still present in the patch. The study noted that the dose remaining in the patch was within the limits of a lethal fentanyl dose.</p> <p>The remaining fentanyl in a used patch is a potential vehicle of abuse and accidental overdose and warrants implementation of adequate disposal policies. Fentanyl products contain several boxed warnings related to potential abuse, misuse, and diversion, and specifically, the contraindication of fentanyl transdermal patch use in individuals who are not opioid tolerant.</p> <p>Staff should dispose of fentanyl patches in the same manner as wasting of any other controlled substances, particularly because the active ingredient is still accessible. Wasting must involve a secure and safe method, so diversion and/or accidental exposure are minimized. ..."</p> <p>On 7/17/13 at 8:20 a.m., when asked if any residents were scheduled to have a medicated patch that day, LN #3 stated she had already</p>	F 431	<p>4. DNS or designee will audit MAR for documentation of fentanyl patch disposal and dating of multiuse vials weekly x 2, 2x month for 1 month and monthly for 2 months. All information will be compiled and forwarded to CQI for additional monitoring/modification.</p> <p>Environmental director or designee will audit medication/treatment cart for trash can lids in place weekly x 2, 2 x month x1 and monthly x3. Information will be compiled and forwarded to CQI for additional monitoring/modification.</p> <p>5. Completion on or before 8/23/13</p>		

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F 431	<p>Continued From page 36</p> <p>changed Resident #12's Fentanyl patch. When asked how Fentanyl patches were wasted, the LN stated, "We have a new procedure. Two nurses have to sign when the used patch is disposed. But, its hard to do sometimes because we don't always have 2 nurses."</p> <p>LN #3 showed 2 surveyors Resident #12's July 2013 MAR. The MAR, and the resident's Physician's Orders for July 2013, included the order, "Fentanyl transdermal (Duragesic) patch 100 mcg [microgram] change [every] 72 hours." Below the order on the MAR, in handwriting was, "[Two] initials to witness old patch disposal." Adjacent to the fentanyl order on the MAR were spaces numbered 1-31, which represented the days of the month. The MAR contained documentation that the fentanyl patch was changed on 7/2/13, 7/5/13, 7/8/13, 7/11/13, 7/14/13, and 7/17/13. LN #3 pointed out that there was only 1 set of initials documented for each day the fentanyl patch was changed. She stated, "There should be 2 nurse signatures in place."</p> <p>The aforementioned documentation revealed a second LN did not witness the disposal of the used fentanyl patches.</p> <p>On 7/18/13 at 3:30 p.m., the Administrator and DON were informed of the issue regarding the disposal of used fentanyl patches. At that time, the facility's policy regarding fentanyl patch disposal was requested.</p> <p>On 7/19/13 at approximately 10:50 a.m., the DON provided a policy entitled, TRANSDERMAL DELIVERY SYSTEMS (PATCHES). This procedure in this policy included, "Remove old patch from body and dispose of properly." In</p>	F 431		
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F 431	<p>Continued From page 37</p> <p>addition, a section entitled, GUIDANCE SPECIFIC TO FENTANYL (DURAGESIC) included, "... 3. Upon patch removal, fold patch over so the adhesive side of the patch adheres to itself. 4. Fentanyl patches may be flushed down the toilet, placed in sharps containers and/or placed in medical waste containers..." This policy did not address the need for 2 LNs to witness the disposal of used fentanyl patches.</p> <p>2. On 7/18/13 at 1:45 p.m., during an inspection of the medication room with LN #2 in attendance, the following opened vials of medications were found without an open date: * Multidose vial of Tubersol; and, * Multidose vial of Pneumovax.</p> <p>LN #2 confirmed both vials of medication were opened and neither of them had an open date. The LN stated she would dispose of them.</p> <p>On 7/18/13 at 3:30 p.m., the Administrator and DON were informed of the issue. No other information was received from the facility which resolved the issue.</p> <p>3. On 7/18/13 at 9:20 a.m., LN #3 was observed as she poured 4 oral medications, one ear drop solution, a supplemental drink and attempted to administer them to Resident #2. However, the resident refused all of the medications.</p> <p>The oral medications (meds) included Toviaz and levothyroxine, both of which were crushed, and a whole capsule of omeprazole. These 3 meds were in a medicine cup with applesauce. When the resident refused the meds, LN #3 returned to the med cart and placed the 3 meds in applesauce in the med cup into the trash</p>	F 431		

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F 431	Continued From page 38 container at the side of the med cart.  Immediately afterward, when asked about disposal of the Toviaz, levothyroxine, and omeprazole, LN #3 acknowledged she had placed them in the trash can. The LN immediately removed the med cup with the 3 aforementioned meds from the trash can and dropped it in the sharps container at the med cart.  On 7/18/13 at 3:30 p.m., the Administrator and DON were informed of the issue. No other information was received from the facility which resolved the issue.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (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.	F 441	F441  1. Glucose monitors have been cleaned with PSS disinfecting wipes. Resident #2's plate was removed from her table. Urinal holder provided to Resident #11  2. Any Resident has the potential to be affected by the practices.	

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F 441	<p>Continued From page 39</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure infection control measures were implemented to prevent the spread of infections in the facility. This was true for 2 of 6 sample residents (#2 and #6), and 2 random residents (#11 and #15). Failure to follow standard infection control measures regarding the use of a multi-resident glucometer for Residents #6 and #15, during dining for Resident #2, and a urinal on Resident #11's over bed table placed the residents at risk for infections. Findings included:</p> <p>1. On 7/16/13 at 4:10 p.m., LN #6 was observed performing a blood glucose (BG) test for Resident #6. After the BG test, the LN took the used glucometer and placed it on top of the medication cart without utilizing a barrier. The LN did not clean the glucometer.</p> <p>At 4:20 p.m., LN #6 took the same unclean</p>	F 441	<p>3. Licensed nurses received in servicing on glucose monitor cleaning and use of Resident's individual glucose monitor. Each Resident has their own glucose monitor. CNAs in serviced 8/5/13, Dietary staff 8/23 /13 and licensed staff 8/14/13 on putting dishes/utensils that have fallen to the floor on a Residents table but to remove the item to the dish room. Residents using urinals have had urinal holders provided to them</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/19/2013	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST 7TH STREET SILVERTON, ID 83867		
(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>glucometer into Resident #15's room where it was placed on the resident's bed without a barrier. During preparation for the finger stick, the LN was asked if the glucometer had been cleaned. The LN stated, "I did not." The LN added that one glucometer was kept on the medication cart and residents were assigned a glucometer which was kept in their rooms. At that point, LN #6 took the unclean glucometer back to the medication cart in the hallway. However, the LN again failed to utilize a barrier under the unclean glucometer. The LN then returned to Resident #15's room and used the glucometer assigned to the resident to complete the BG test.</p> <p>Regarding indirect transmission, F441 states, "Indirect transmission involves the transfer of an infectious agent through a contaminated intermediate object. The following are examples of opportunities for indirect contact. Resident-care devices (e.g. [example given], ...glucose monitoring devices) may transmit pathogens if devices contaminated with blood or body fluids are shared without cleaning and disinfecting between uses for different residents..."</p> <p>On 7/18/13 at 3:30 p.m., the Administrator and DON were informed of the infection control issue with the glucometer. No other information was received from the facility.</p> <p>2. On 7/17/13 at 7:20 a.m., during a breakfast meal observation, Resident #2 was observed to place her plate of food on the floor next to her wheelchair. Almost immediately, CNA #7 picked up the plate and placed it near the middle of the table which was about 2 feet away from the resident.</p>	F 441	<p>4. DNS or designee will audit licensed nurse use of glucometers and their cleaning after use q day x 7, q wk x2, 2x mo x1 and monthly x3, Information will be compiled and forwarded to CQI for additional monitoring/modification. Dietary manager or designee will audit meal time for removal of items from the floor 1x day x 7, 1x wk x2, 2x mo x1 mo and q month x 3. Information will be compiled and forwarded to CQI for additional monitoring/modification. DNS or designee will audit urinal location 1 x wk x 2, 2x mo x 1, q month x 3. Information will be compiled and forwarded to CQ1 for additional monitoring/modification.</p> <p>5. Completion date on or before 8/23/13</p>	

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F 441	<p>Continued From page 41</p> <p>At 7:25 a.m., the Dietary Manager (DM) came to the resident's table and moved the plate in front of the resident and encouraged her to eat. The DM then went to another resident's table.</p> <p>At 7:28 a.m., the DM was informed of the observation of the Resident #2's plate on the floor. The DM immediately went back to the resident's table, removed the plate, and offered the resident more food.</p> <p>At 7:40 a.m., CNA #7 was interviewed about the observation of the resident's plate on the floor. The CNA stated, "I put it off to the side." The CNA indicated she thought the plate was not within the resident's reach. When informed another staff had moved the unclean plate back in front of the resident, CNA #7 stated, "Oh!" and nodded yes.</p> <p>On 7/18/13 at 3:30 p.m., the Administrator and DON were informed of the infection control issue. No other information was received from the facility.</p> <p>3. On 7/18/13 at 9:45 a.m., during a medication pass by LN #3 and with the Social Services Designee present, a urinal was observed on Resident #11's over bed table. A water carafe covered with a glass and a box of tissues were also on the over bed table.</p> <p>Immediately afterward, LN #3 was asked about the urinal. The LN said the resident did use the urinal sometimes. She stated, "He probably put it on the table himself."</p> <p>On 7/18/13 at 3:30 p.m., the Administrator and DON were informed of the issue. No other</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST 7TH STREET SILVERTON, ID 83867
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<p>F 441</p> <p>F 514 SS=D</p>	<p>Continued From page 42 information was received from the facility.</p> <p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</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' clinical records were complete. This was true for 1 of 10 sample residents (#2) when a urine culture and sensitivity (C&amp;S) report was not in Resident #2's clinical record. Failure to have the urine C&amp;S report in order to know which antibiotic(s) the offending organism was sensitive or resistant to created the potential for Resident #2 to receive the wrong antibiotic medication for a urinary tract infection (UTI). Findings included.</p> <p>Resident #2 was admitted to the facility on 1/21/13 with multiple diagnoses which included Alzheimer's disease and hypertonicity of the bladder.</p>	<p>F 441</p> <p>F 514</p>	<p>F514</p> <ol style="list-style-type: none"> <li>Resident #2 C&amp;S report was obtained and placed on her chart.</li> <li>Any Resident with a UTI has the potential to be affected by this practice.</li> <li>Licensed nurses were in-service on necessity of C&amp;S prior to UTI treatment 8/14/13</li> <li>DNS or designee will audit UA C &amp; S lab results are obtained before treatment is begun 1 x wk x 4, 2x mo x 1 month, monthly x 3. Information will be compiled and forwarded to CQI for additional monitoring/modification.</li> <li>Compliance on or before 8/23/13.</li> </ol>	
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F 514	<p>Continued From page 43</p> <p>The resident's admission and quarterly MDS assessments, dated 2/4/13 and 4/22/13 respectively, both coded, in part:</p> <ul style="list-style-type: none"> <li>* Severe cognitive impairment, with a BIMS score of 3;</li> <li>* Extensive assistance for bed mobility/transfers/toileting/personal hygiene/bathing; and</li> <li>* Frequent bowel and urinary incontinence.</li> </ul> <p>Review of the resident's clinical record revealed:</p> <ul style="list-style-type: none"> <li>* A Physician's Progress Note, dated 3/28/13, which documented, "...Nurses note odor of urine. Sample sent for C&amp;S. [Negative] nitrite, large blood. She has no symptoms. Afebrile, appetite fair, VSS [vital signs stable]. Will begin Bactrim DS [times] 7 days."</li> <li>* No urine urine C&amp;S report for March 2013.</li> </ul> <p>On 7/18/13 at about 10:30 a.m., during an interview with the DNS regarding the facility's infection control program, the DNS was asked about the 3/28/13 urine C&amp;S report for Resident #2. The DNS stated she would research the issue and get back with the surveyor.</p> <p>On 7/18/13 at 2:20 p.m., the DNS stated she had not found the 3/28/13 urine C&amp;S report for Resident #2 and she called the lab and requested a copy. The DNS stated the lab faxed the report to the facility that day and it showed the identified organism, e-coli, was sensitive to the Bactrim. The DNS confirmed that for almost 4 months, the facility did not know if the antibiotic prescribed for Resident #2's UTI was appropriate or not.</p> <p>On 7/18/13 at 3:30 p.m., the Administrator was also informed of the issue. No other information or documentation was received which resolved</p>	F 514		

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F 514	Continued From page 44 the issue.	F 514			

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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - SILVER WOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST 7TH STREET SILVERTON, ID 83867
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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 your annual State licensure survey.  The survey team included:  Nina Sanderson LSW BSW Linda Kelly RN Lauren Hoard RN	C 000		
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 see F 329 as it pertains to monitoring with the use of antipsychotic medications.	C 147	C147 See POC for F329	
C 325	02.107,08 FOOD SANITATION  08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare	C 325	C325 See POC for F371	

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AUG 20 2013  
FACILITY STANDARDS

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

TITLE

(X6) DATE

*[Signature]*

Administrator

8/16/13

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001740	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/19/2013
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C 325	Continued From page 1 Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Please refer to F 371 as it relates to sanitary food conditions.	C 325		
C 393	02.120,04,b Staff Calling System at Each Bed/Room  b. A staff calling system shall be installed at each patient/resident bed and in each patient/resident toilet, bath and shower room. The staff call in the toilet, bath or shower room shall be an emergency call. All calls shall register at the staff station and shall actuate a visible signal in the corridor at the patient's/resident's door. The activating mechanism within the patient's/resident's sleeping room shall be so located as to be readily accessible to the patient/resident at all times. This Rule is not met as evidenced by: Please refer to F 246 as it relates to call lights.	C 393	C393 See POC for F 246	
C 664	02.150,02,a Required Members of Committee  a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of the Infection Control Meeting Minutes, it was	C 664	C664  1. Consulting pharmacist attended Infection control meeting 7/22/13 and Medical Director attended 8/22/13.	

Bureau of Facility Standards

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C 664	Continued From page 2 determined the facility failed to ensure the Pharmacist and the Medical Director attended the Infection Control Meetings. This had the potential to affect all residents, staff and visitors in the facility. Findings included:  Review of monthly infection control attendance logs for 3/12/13, 4/15/13, 5/8/13, and 6/3/13 revealed the Physician and the Pharmacist had not signed any of the aforementioned attendance logs.  On 7/18/13, at 12:35 p.m., when asked about committee member attendance, the DNS who was also the Infection Preventionist stated, "You won't see the Pharmacist or the Physician's name on there."  On 7/18/13, at 3:30 p.m., the Administrator was informed of the issue. No other information or documentation was received from the facility that resolved the issue.	C 664	2. All Residents are potentially affected by this practice.  3. Pharmacist was requested to attend quarterly infection control meetings 7/22/13 and Medical Director was requested to attend infection control meetings quarterly 7/25/13.  4. HIM/ designee will audit Infection control minutes for appropriate Attendees q month. Information will be compiled and forwarded to CQI for additional monitoring/modification.	
C 669	02.150,03 PATIENT/RESIDENT PROTECTION  03. Patient/Resident Protection. There is evidence of infection control, prevention and surveillance in the outcome of care for all patients/residents as demonstrated by: This Rule is not met as evidenced by: Please refer to F 441 as it relates to infection control of glucometers.	C 669	5. Completion on or before 8/23/13  C669 See POC for F441	
C 779	02.200,03,a,i Developed from Nursing Assessment  i. Developed from a nursing	C 779	C779 See POC for F272	

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C 779	Continued From page 3  assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Please refer to F 272 as it relates to restraint assessment.	C 779		
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 relates to revision of care plans.	C 782	C782 See POC for F280	
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 see F 309 as it pertains to Coumadin management, and to monitoring behavioral changes in residents with dementia.	C 784	C784 See POC for F309	
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered  iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by:	C 788	C788 See POC for F309	

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C 788	Continued From page 4 Please refer to F 309 as it relates to following physician's orders.	C 788		
C 790	02.200,03,b,vi Protection from Injury/Accidents  vi. Protection from accident or injury; This Rule is not met as evidenced by: Please refer to F 323 as it relates to increased supervision to prevent injury.	C 790	C790 See POC for <sup>F</sup> 323	
C 797	02.200,03,c Documentation of Nursing Assessments  c. Nursing staff shall document on the patient/resident medical record, any assessments of the patient/resident, any interventions taken, effect of interventions, significant changes and observations and the administration of medications, treatments and any other services provided. Entries shall be made at the time the action occurs and shall be signed by the person making the entry and shall provide the time and date of the occurrence. At a minimum, a monthly summary of the patient's/resident's condition and reactions to care shall be written by a licensed nursing staff person. This Rule is not met as evidenced by: Please refer to F 309 as it relates to monitoring resident behaviors and interventions.	C 797	C797 See POC for F309	
C 811	02.200,04,g,vii Medication Errors Reported to Physician  vii. Medication errors (which shall	C 811	C811 See POC for 322 F 332	LK

Bureau of Facility Standards

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GOOD SAMARITAN SOCIETY - SILVER WOOD 405 WEST 7TH STREET  
SILVERTON, ID 83867

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C 811	Continued From page 5  be reported to the charge nurse and attending physician. This Rule is not met as evidenced by: Please refer to F 332 as it relates to medication error rate of five percent or more.	C 811		
C 822	02.201,01,c Medication Storage and Dangerous Chemicals  c. Reviewing the facility for proper storage of medications and dangerous chemicals at least every thirty (30) days and notifying the administrator of the facility of any nonconformance.  This Rule is not met as evidenced by: Please refer to F 431 as it relates to disposal of controlled medication and storage.	C 822	C822 See POC for F431	
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD  02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Please refer to F 514 as it relates to maintaining a complete medical record.	C 881	C881 See POC for <sup>F</sup> 514	