



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

**CERTIFIED MAIL: 7012 1010 0002 0836 2304**

August 27, 2013

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

Provider #: 135067

Dear Ms. Berg:

On **August 15, 2013**, a Recertification and State Licensure survey was conducted at Good Samaritan Society - Moscow 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 a widespread deficiency 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

Jamie M. Berg, Administrator  
August 27, 2013  
Page 2 of 4

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 **September 9, 2013**. Failure to submit an acceptable PoC by **September 9, 2013**, may result in the imposition of civil monetary penalties by **September 30, 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.

Jamie M. Berg, Administrator  
August 27, 2013  
Page 3 of 4

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **September 19, 2013 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **September 19, 2013**. A change in the seriousness of the deficiencies on **September 19, 2013**, may result in a change in the remedy.

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

Denial of payment for new admissions effective **November 15, 2013**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 15, 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.

Jamie M. Berg, Administrator  
August 27, 2013  
Page 4 of 4

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 **August 15, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **September 9, 2013**. If your request for informal dispute resolution is received after **September 9, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

LKK/dmj  
Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>135067</b>	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: <b>8/15/2013</b>
--	---------------------------------	--	--

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAG</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID</b>
---	--

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
---------------------	-----------------------------------

<b>F 204</b>	<p><b>483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG</b></p> <p>A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.</p> <p>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r).</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 discharged residents' belongings were accounted for at discharge. This affected 2 of 2 (#s 14 &amp; 15) closed records reviewed. Findings included:</p> <ol style="list-style-type: none"> <li>1. Resident #14 was admitted to the facility on 4/2/13 with multiple diagnoses including aftercare for healing of hip fracture and unspecified disorder of skin and subcutaneous tissue. The resident discharged on 5/31/13.</li> </ol> <p>Review of the resident's Inventory of Personal Effects form, Interdisciplinary Progress Notes, and Daily Skilled Notes did not provide evidence the resident's belongings were accounted for.</p> <ol style="list-style-type: none"> <li>2. Resident #15 was admitted to the facility on 6/18/07 with multiple diagnoses including aftercare for fracture of upper leg and fracture of lower end of femur. The resident discharged on 7/14/13.</li> </ol> <p>Review of the resident's Inventory of Personal Effects form and Interdisciplinary Progress Notes did not provide evidence the resident's belongs were accounted for.</p> <p>On 8/15/13 at 9:40 a.m., the surveyor and the Director of Health Information Management (DHIM) reviewed Resident #14's and Resident #15's medical records. The DHIM stated, "The medical records do not contain documentation [Resident #14's and Resident #15's] belongings were accounted for."</p> <p>On 8/15/13 at 5:10 p.m., the Administrator was informed of the above findings. The facility did not provide any additional information.</p>
<b>F 278</b>	<p><b>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</b></p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p>

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>135067</b>	MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	DATE SURVEY COMPLETE.  <b>8/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGI</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID</b>	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
<b>F 278</b>	<p>Continued From Page 1</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to accurately code Section L of a resident's MDS. This affected 1 of 9 (#7) sampled residents. Findings included:</p> <p>Resident #7 was admitted to the facility on 2/2/11 with multiple diagnoses including debility and care involving physical and occupational therapy.</p> <p>Resident #7's 6/21/13 significant change MDS coded severely impaired cognition. Section L, coded, "broken or loose fitting denture, cavity or broken natural teeth and inflamed/bleeding gums or loose teeth." Section V identified Dental Care triggered but was not care planned.</p> <p>The resident's 7/1/13 Dental Care, Care Area Assessment documented the care area was triggered by broken or loose fitting denture, cavity or broken natural teeth and inflamed/bleeding gums or loose teeth. The section titled "Factors to review for relationship to Dental Care" documented, "have found no documentation of broken or loose denture, cavity or [broken natural teeth]..." The form was electronically signed by RN #2.</p> <p>On 8/15/13 at 10:00 a.m., the surveyor and RN #2 discussed the resident's dentition. The RN stated, "I must have checked the wrong sections on the MDS. I just checked Resident #7's mouth and Resident #7 does not have these issues identified in Section L of the MDS [broken or loose fitting denture, cavity or broken natural teeth and inflamed/bleeding gums or loose teeth]." The RN said a correction to the MDS would be completed and submitted.</p> <p>On 8/15/13 at 5:10 p.m., the Administrator was informed of the finding. The facility did not provide any additional information.</p>		

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/15/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 640 NORTH EISENHOWER STREET MOSCOW, ID 83843
---	--

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

F 000 INITIAL COMMENTS

The following deficiencies were cited during the annual recertification survey of your facility.

The surveyors conducting the survey were:

Karen Marshall, MS, RD, LD Team Coordinator  
Arnold Rosling, RN, BSN, QMRP  
Debra Bernamonti, RN  
Karla Gerleve, RN

Survey Definitions:  
ADL = Activities of Daily Living  
BID = Twice a day  
BIMS = Brief Interview for Mental Status  
CAA = Care Area Assessment  
CNA = Certified Nurse Aide  
DON = Director of Nursing  
FDA = Federal Drug Administration  
GDR = Gradual Dose Reduction  
HS = Hour of sleep  
HX = History  
LPN = Licensed Practical Nurse  
MAR = Medication Administration Record  
MDS = Minimum Data Set assessment  
MG = Milligrams  
ML = Millileters  
NSF = National Sanitation Foundation  
PO = By mouth  
PRN = As needed  
QD = Every Day  
Recap = Physician Recapitulation Orders  
RN = Registered Nurse  
TAR = Treatment Administration Record  
TR = Treatment Record

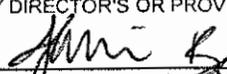
F 155 483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES  
SS=D

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.

**RECEIVED**  
**SEP 10 2013**  
**FACILITY STANDARDS**

9/19/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 9-9-13
--	------------------------	---------------------

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

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	<p>Continued From page 1</p> <p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</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 advanced directives accurately reflected the residents' wishes. This affected 1 out of 9 (#12) sampled residents. This discrepancy put the resident at risk by not having the proper documents in place to ensure her rights and wishes could be followed. Findings include:</p> <p>Idaho's Medical Consent and Natural Death Act documents: 39-4512A. Physician orders for scope of treatment (POST). (1) A physician orders for scope of treatment (POST) form is a health care provider order signed by a physician or by a PA or</p>	F 155	<p><b>F 155 SS=D</b></p> <p>1 Resident #12 was interviewed by LSW regarding POST status on 8/15/13. The physician was contacted to communicate resident wishes and a new POST was signed 8/15/13.</p> <p>2. All residents with POSTS have the potential to be affected by this practice. All residents' records will be reviewed to ensure POST and Physician orders are consistent.</p> <p>3. All advance directives/POSTs will be reviewed with resident on admission, care conferences, and upon resident request. The IDT will be re-educated on the new process.</p> <p>4. Audits will be completed Monthly X 3 months, Quarterly X 1. All results will be reviewed reported to QA/CQI for furthering monitoring and modifications. DNS or designee will ensure compliance.</p> <p>5. Compliance on or before Sept 19, 2013</p>	9/19/2013

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	<p>Continued From page 2</p> <p>by an APPN. The POST form must also be signed by the person, or it must be signed by the person's surrogate decision maker provided that the POST form is not contrary to the person's last known expressed wishes or directions.</p> <p>(2) The POST form shall be effective from the date of execution unless suspended or revoked.</p> <p>(3) The attending physician...shall, upon request of the person or the person's surrogate decision maker, provide the person or the person's surrogate decision maker with a copy of the POST form, discuss with the person or the person's surrogate decision maker the form's content and ramifications and treatment options, and assist the person or the person's surrogate decision maker in the completion of the form.</p> <p>Resident #12 was admitted to facility 08/23/12 with Physician's Orders for CPR (cardio-pulmonary resuscitation).</p> <p>Nurse's notes dated 01/02/13 at 9 p.m. documented the resident had an unwitnessed fall and was sent to the local emergency room for evaluation and treatment of a possible left hip fracture. According to the hospital History and Physical the Physician spoke with resident's daughter who requested that her mother's code status be a Do Not Resuscitate (DNR).</p> <p>The resident was re-admitted to the facility on 01/08/13 with a DNR order. The resident's record included documentation by the LSW on 01/08/13 of a discussion with the resident's daughter confirming the DNR. The DNR was updated in the comprehensive nursing care plan, however, the POST at the front of the medical record was not updated to reflect this change.</p>	F 155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/15/2013
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 640 NORTH EISENHOWER STREET MOSCOW, ID 83843		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 155	Continued From page 3 When interviewed about the resident's code status on 08/15/13 at 10:05 a.m., the LSW and she said would take care of it. The LSW discussed the code status with the resident, resident's daughter and Physician. The resident expressed wishes to be a full code.	F 155			
F 176 SS=D	The Administrator and DON were notified 08/15/13 at 5 p.m. and updated documentation was presented at that time. 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interview, it was determined the facility failed to ensure residents who self-administered medications were assessed by the Interdisciplinary Team (IDT) and appropriate annotations were made in the resident's care plan. This affected 1 of 9 (#3) sampled residents. This practice created the potential for the resident to not receive the medication as ordered by the resident's physician. Findings included:  Resident #3 was admitted to the facility on 9/19/12 with multiple diagnoses including generalized pain and aftercare for fractured left humerus.  The resident's 6/18/13 MDS coded cognition	F 176	F 176 SS=D  1. Resident #3 was reviewed by IDT for safety for self-administration of meds.  2. All residents who self administer meds have the potential to be affected and will be audited for IDT review.  3. IDT will determine the safety of self administration of meds prior to initiation. IDT will be educated on process.  4. Audits will be completed Monthly X 3 months. All results will be reviewed reported to QA/CQI for furthering monitoring and modifications. DNS or designee will ensure compliance.  5. Compliance on or before Sept. 19, 2013.	9/19/2013	

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 176	<p>Continued From page 4 intact.</p> <p>On 8/13/13 at 8:40 a.m., the surveyor spoke with Resident #3 about the medical services she received in the facility. Resident #3 stated, "I had an infection in my right eye. I had antibiotics but now I have liquid tears. I put the liquid tears in my eye myself." The resident then showed the surveyor a medication that appeared to be artificial tears generic equivalent in a plastic zip lock bag located in the resident's dresser drawer.</p> <p>The resident's medical record did not provide evidence the IDT assessed the resident as safe to self-administer medications. In addition, the resident's 8/6/13 Comprehensive Care Plan did not contain a problem/need/concern area or plan and approach (intervention) for self-administration of medications.</p> <p>The resident's 8/13 Physician's Orders (recapitulation) contained an order initiated 7/10/13 for artificial tears 1-2 drops right eye every 1 hour as needed. "May administer at bedside."</p> <p>The resident's 8/13 TR contained on the left side pre-printed entries, 7/10/13, artificial tears 1-2 drops right eye every 1 hour as needed. May administer at bedside. The date blocks on the TR contained a pre-printed entry, document response to treatment on reverse side. The back of the TR did not contain any entries.</p> <p>On 8/15/13 at 9:09 a.m., RN Care Manager #1 stated, "I looked through [Resident #3's] chart and did not find a self-administration assessment."</p>	F 176			

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/15/2013
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 640 NORTH EISENHOWER STREET MOSCOW, ID 83843	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 5	F 176		
F 225 SS=D	On 8/15/13 at 5:09 p.m., the Administrator was informed of the finding. The facility did not provide any additional information.  483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.  The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the	F 225	F 225 SS=D  1. All staff members were interviewed regarding the incident with resident #17, and note was added to the Incident Report on 8/18/2013.  2. All residents with injuries of unknown origin have the potential to be affected. All incidents of unknown origin will be reviewed for past three months.  3. All staff members that had contact within 72 hours of a resident with an injury of unknown origin will be interviewed and the results documented. At-Risk Committee will be re-educated on the investigation process.  4. Injuries of unknown origin will be audited weekly x 6 weeks and monthly for 3 months. All results will be monitored by LSW/designee and reported to QA/CQI for further monitoring and modification.  5. Compliance on or before Sept 19, 2013	9/19/2013

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 6</p> <p>incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to investigate an injury of unknown origin for 1 of 3 (# 17) abuse investigations reviewed. Failing to investigate injuries of unknown origin could lead to potential harm to a resident who may be a subject of staff abuse. Findings include:</p> <p>Resident #17 was admitted to the facility on 2/27/13 with diagnoses of cerebral vascular accident, expressive aphasia and generalized pain.</p> <p>The most recent quarterly MDS, dated 5/30/13 documented the resident: * had short and long term memory issues, * required minimal assistance for transfers, ambulation, dressing, personal hygiene and bathing.</p> <p>An Incident Report dated 5/31/13 at 1:45 a.m., documented the resident, "complained of right shoulder pain. Slight swelling...Resident very precise as to where pain is...denied falling and cannot explain why shoulder hurts...has slight bruise...on back on right side. Denies knowledge of how he got it." The Incident Report further documented, "Resident unable to elaborate on why shoulder hurt. Made 1 statement of, 'He pulled on it' but did not go further with report."</p> <p>The resident was transferred to the local</p>	F 225			

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	<p>Continued From page 7</p> <p>emergency room on 5/31/13 at 4:18 p.m. The physician's diagnosis was, "acute anterior dislocation of the affected area...Radiologic study shows: chip fx [fracture], partial dislocation, anterior." The physician performed a closed reduction of the shoulder in the emergency room, and he was put in an immobilizer. The resident was transferred back to the nursing home.</p> <p>Review of the facility's procedure for "Abuse and Neglect" documented in part:</p> <p>"6. The investigation team (social worker, the administrator and the director of nursing services) will review all Incident Reports that involve residents including those that indicate an injury of unknown origin,...</p> <p>7. The investigation may include interviewing staff, residents or other witnesses to the incident. Interview all involved (staff, resident and family) individually, not as a group, so that you can compare their descriptions of the incident to determine any inconsistencies. You may want to have each person write his/her memory of the event. If possible, get signed and dated statements from any witness..."</p> <p>The facility investigated the injury and submitted it to the state on 6/11/13 at 3:40 p.m. The investigation was not complete as the facility failed to interview any of the staff who worked the evening or night shift prior to the discovery of the injury.</p> <p>The facility's conclusion was based on a history of the resident hurting his arm prior to admission. Neither of the two injuries he had previously were dislocations of the shoulder and were resolved without medical intervention. A dislocation would require a greater force to make it happen and</p>	F 225		



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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/15/2013
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 640 NORTH EISENHOWER STREET MOSCOW, ID 83843	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 9 entered the room was visibly soiled (dark grayish stain) at the headrest area (14 inches x 6 inches), arms (6 inches x 4 inches rectangular shape) and seat (2 areas of irregular circles of a darker brown color, approximately 7 inches x 4 inches and 9 inches x 6 inches).  *The same was true with the burgundy colored recliner/lift chair (12 inches x 8 inches irregular brownish circle) and blue rocker (10 inches x 6 inches brownish irregular circle) located near the piano. There was also a "urine" smell present.  The condition of the chairs was discussed with the housekeeping supervisor on 08/14/13 at 1:50 p.m. She stated that she had not been told that the chairs needed to be cleaned. No further information was provided.	F 252		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE 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;	F 272	F 272 SS=D  1. Resident's #7 & #3 positioning devices were reassessed for safety and the potential for entrapment and potential harm.  2. All residents with positioning devices attached to resident's beds have the potential to be affected. All residents with positioning devices will be reassessed for safety and the potential for entrapment and potential harm.  3. A statement will be put into the residents' record, upon assessment, for safety and the potential for entrapment and potential harm of positioning devices attached to the residents' beds. RN Care Managers will be re-educated on the process.  4. Positioning device assessments will be audited monthly x 3. All results will be monitored by the DNS/designee and reported to QA/CQI for further monitoring and modification.  Compliance on or before Sept 19, 2013	9/19/2013

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 272	<p>Continued From page 10</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure the use of positioning devices attached to residents' beds were assessed as safe for the residents to use. This affected 2 of 9 (#s 3 &amp; 7) sampled residents. This practice placed the residents at risk for entrapment and potential harm should the residents become entrapped in the positioning devices. Findings included:</p> <p>1. Resident #7 was admitted to the facility on 2/2/11 with multiple diagnoses including debility and care involving physical and occupational therapy.</p>	F 272			

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 272	<p>Continued From page 11</p> <p>Resident #7's 6/21/13 significant change MDS coded severely impaired cognition and required extensive assist of two or more persons for transfers and bed mobility.</p> <p>Resident #7's 3/21/13 Physical Restraint Review form documented "positioning bars bilateral" were reviewed for use. The form did not include the bilateral positioning bars were determined to be safe for the resident to use.</p> <p>Resident #7's 7/2/13 Comprehensive Care Plan identified impaired mobility manifested by inability to transfer independently. One of the approaches was "positioning bars" to help maintain bed mobility.</p> <p>Resident #7's 8/13 Physician's Orders (recapitulation) contained the 3/2/11 order, "positioning bars on bed to assist with increased mobility."</p> <p>On 8/13/13 at 7:47 a.m., the surveyor observed two devices attached bilaterally near the head of the resident's bed. These devices appeared to be a type of assistive device.</p> <p>On 8/15/13 at 10:20 a.m., the surveyor informed RN #2 that the Physical Restraint Review form did not include the bilateral positioning bars were determined as safe for the resident to use. The RN stated, "We will include the verbiage and this will be corrected today."</p> <p>2. Resident #3 was admitted to the facility on 9/19/12 with multiple diagnoses including generalized pain and aftercare for fractured left humerus.</p>	F 272			

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 272	Continued From page 12 The resident's 6/18/13 MDS coded cognition intact and required set up help with bed mobility and transfers.  Resident #3's 9/20/12 Physical Restraint Review form documented "positioning bars on bed" were reviewed for use. The form did not include the positioning bars were determined to be safe for the resident to use.  Resident #3's 8/6/13 Comprehensive Care Plan identified alteration in mobility related to left arm stiffness and history of falls. One of the plans and approaches was positioning bars (on) bed to assist with independence in bed mobility.  On 8/13/13 at 8:40 a.m., the surveyor observed bars attached at both sides of the resident's bed near the head of the bed. The surveyor asked Resident #3 what the bars were used for. Resident #3 stated, "I used those bars when I had my broken arm. The bars helped me move around in bed. I do not use those bars now since my arm healed."  On 8/15/13 at 10:31 a.m., RN Care Manager #1 stated, "I reviewed the positioning device evaluation form. The form did not include the resident was assessed as safe to use the positioning device."	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	F 280			

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	<p>Continued From page 13</p> <p>incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the areas triggered by the RAI process were care planned as identified in the CAA and that care plans were updated as needed. This affected 2 of 9 (#s 2 &amp; 7) sampled residents. This practice created the potential for harm due to the lack of direction in the care plan. Findings included:</p> <p>1. Resident #7 was admitted to the facility on 2/2/11 with multiple diagnoses including debility and care involving physical and occupational therapy.</p> <p>Resident #7's 3/27/13 quarterly MDS coded moderate cognitive impairment and no signs or</p>	F 280	<p>F 280 SS=D</p> <ol style="list-style-type: none"> <li>The care plan of residents #2 &amp; #7 were updated.</li> <li>All residents have the potential to be affected. All residents' care plans will be audited to ensure that the areas triggered by the RAI process as identified in the CAA are added to the care plan.</li> <li>CAA areas triggered will be carried over to the care plan or a statement written as to why it isn't being care planned. IDT Care Managers will be re-educated on the documentation process.</li> <li>CAA and Care plans will be audited monthly x 3. All results will be monitored by the DNS/designee and reported to QA/CQI for further monitoring and modification.</li> </ol> <p>Compliance on or before Sept. 19, 2013</p>	9/19/2013	

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	<p>Continued From page 14 symptoms of delirium Section C1300.</p> <p>Resident #7's 6/21/13 significant change MDS coded severe cognitive impairment and no signs or symptoms of delirium. Section V identified the care area Delirium triggered and was care planned.</p> <p>Resident #7's 6/27/13 Delirium CAA documented the resident had worsening mental status and the Proceed to Care Plan section was "Yes."</p> <p>Review of the resident's Comprehensive Care Plan (CCP) did not provide evidence the Delirium Care Area was care planned as identified on the 6/27/13 CAA.</p> <p>On 8/15/13 at 10:20 a.m., the surveyor and RN #2 reviewed the resident's CCP. RN #2 stated, "I do not see that we care planned Delirium."</p> <p>On 8/15/13 at 5:10 p.m., the Administrator was informed of the finding. The facility did not provide any additional information related to the finding.</p> <p>2. Resident #2 was admitted to the facility on 6/27/11 with diagnoses of persistent mental disorder, dementia, Alzheimer's disease, depressive disorder and insomnia unspecified.</p> <p>The August 2013 physician's recapitulation orders documented the resident to have: Lexapro 20 mg tablet orally each morning for depression (started 5/21/12), Trazodone 50 mg orally at bedtime for insomnia (started 1/12/13) and may have Trazodone 50 mg 1/2 tablet orally as needed one time at night for occasional restlessness (started 1/12/13).</p>	F 280			

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>
--	--

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

F 280	<p>Continued From page 15</p> <p>The most recent quarterly MDS, dated 7/24/13, documented the resident:</p> <ul style="list-style-type: none"> <li>* was moderately impaired with cognition BIMS = 9,</li> <li>* did not have problems with, "Trouble falling or staying asleep, or sleeping to much" or "Feeling tired or having little energy."</li> </ul> <p>The significant change MDS assessment, dated 2/6/13, triggered Psychotropic Drug Use CAA.</p> <p>The Psychotropic Drug Use CAA, dated 2/16/13, documented to proceed to care planing. The reason they were to proceed was, "Resident should continue to be monitored for adverse effects to medication use." The facility did not address the reason for use of psychotropic medications.</p> <p>The resident's comprehensive care plan did not address insomnia. There was no interventions provided in the care plan for using antidepressant medications and for using non-pharmacological alternatives before medications.</p> <p>On 8/15/13 at 5:10 p.m., the Administrator was informed of the finding. The facility did not provide any additional information related to the finding.</p> <p>Refer to F329 for additional information regarding antipsychotic medication use.</p>	F 280		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p>	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 16</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to ensure an outdated medication was removed from the medication cart and was not available for resident use. This failed practice caused Random Resident #16 to receive an expired laxative which had the potential to affect the efficacy of the medication. This was true for 1 of 3 medication carts inspected for expired medications. Findings included:</p> <p>Pharmacology and the Nursing Process, Fifth Edition, 2007, "Nurses may reduce the likelihood of medication errors by taking the following precautions...carefully reading all labels for accuracy and expiration dates..."</p> <p>On 8/14/13 at 1:00 pm, the 100 Hall Medication Cart was inspected for expired medication. A bottle read, "[Resident #16's name] Senna Syrup 218mg/5ml, Use daily as needed, Filled 9/27/12, Expiration 10/12" was observed in a drawer with other PRN [as needed] medications. The surveyor asked RN #1 to read the expiration date on the bottle. RN #1 said "10/12." The surveyor asked RN #1 what she would do with the medication. RN #1 said, "I will dispose of it." The surveyor asked to see Resident #16's MAR. RN #1 provided Resident #16's August 2013 MAR that documented in part: "9/27/12 Senokot 187mg/5.3125 ML PO QD PRN". The Senokot medication on the MAR was initialed as given to Resident #16 on 8/6/13. The surveyor asked RN #1 if this documentation showed the expired Senna Syrup was given to Resident #16 on 8/6/13. RN #1 said, "Yes, it was given."</p>	F 281	<p>F 281 SS=D</p> <ol style="list-style-type: none"> <li>1. The expired medication for resident #16 was removed from the cart on 8/14/13.</li> <li>2. All residents have the potential to be affected. All med carts and med room will be audited to ensure that there are no outdated medications.</li> <li>3. Night nurses will check med storage room and carts monthly for outdated meds and dispose of according. LNs educated on process.</li> <li>4. Audits will be completed monthly for 3 months. The results will be monitored by the DNS/designee and reported to QA/CQI for further monitoring and modification.</li> <li>5. Compliance on or before Sept. 19, 2013</li> </ol>	9/19/2013	

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/15/2013
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 640 NORTH EISENHOWER STREET MOSCOW, ID 83843		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	Continued From page 17 On 8/15/13 at 3:35 pm, the Administrator and DON were informed of administration of expired medication for Resident #16. No documentation or information was provided which resolved the issue.	F 281			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  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 observations, review of medical records and staff interview, it was determined the facility failed to provide necessary care and services to maintain quality of care. This affected 1 of 9 (#5) sampled residents. Not wearing physician ordered TED (anti-embolism) hose placed Resident #5 at risk for exacerbation of her cardiac symptoms. Findings include:  The comprehensive nursing care plan for Resident #5 dated 6/11/13 stated the problem of: "Alteration in cardiac output r/t (related to) htn (hypertension), hyperlipidemia m/b (manifested by) increased bp (blood pressure), activity intolerance and edema." The care plan and the recapitulated physician's orders signed on 7/31/13 stated that Resident # 5 was to have, "knee high TED hose on AM and off at HS."	F 309 SS=D	<ol style="list-style-type: none"> <li>1. Ted hose were obtained for resident #5.</li> <li>3. All residents with orders for ted hose have the potential to be affected. All residents with ted hose will be audited for use.</li> <li>4. CNA will inform nurse immediately when necessary supplies are not available. CNAs/LN will be educated on what to do when there is a deviation in the process.</li> <li>5. Ted hose documentation and use will be audited weekly x 4. All results will be monitored by the DNS/designee and reported to QA/CQI for further monitoring and modification.</li> <li>5. Compliance on or before Sept. 19, 2013</li> </ol>	9/19/2013	

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 18 On 8/13/13 at 8:15 a.m. during breakfast observation, the surveyor noticed Resident # 5 had regular socks on. This same observation was repeated on 8/14 and 8/15. When asked about the socks on 8/15/13 at breakfast time, CNA's #3 response was, "the night shift dresses her in the mornings before I get here."  The MAR documented that the TED hose were on the morning and off at night daily from 8/01/13 to 8/15/13. During an interview with RN #5 and CNA #3 on 8/15/13 after breakfast, CNA #3 stated that she spoke with the night shift and was told the TED hose had been missing for the last 2 weeks and that is why they were not on the resident. RN #5 stated that no one had made her aware of this.	F 309		
F 328 SS=D	The administrator and DON were notified of this finding on 8/15/13 at 5 p.m. No additional information was provided. 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.  This REQUIREMENT is not met as evidenced	F 328	F 328 SS=D  1. Resident #8's O2 was set to the flow rate per physician's order.  3. All residents with O2 have the potential to be affected. All residents with O2 will be audited to ensure the flow rate is per physician's orders.  4. The flow rate will be checked every shift by the licensed nurse to ensure. LNs will be educated on the new process.  O2 will be audited weekly x 4 and monthly x 2. All results will be monitored by the DNS/designee and reported to QA/CQI for further monitoring and modification.  5. Compliance on or before Sept. 19, 2013	9/19/2013

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>	
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	<p>Continued From page 19</p> <p>by:</p> <p>Based on observation, record review and staff interviews, it was determined the facility failed to ensure physician's orders were followed for the administration of oxygen (O2). This affected 1 of 3 (#8) residents sampled for oxygen therapy. This practice created the potential for harm should a resident receive oxygen therapy at higher concentrations than ordered by the physician. Findings included:</p> <p>Resident #8 was admitted to the facility 8/30/06 with multiple diagnoses including dementia with behavioral disturbances and pneumonia.</p> <p>Resident #8's 6/5/13 annual MDS coded severe cognitive impairment and received oxygen therapy. Section V did not trigger for delirium or fluid maintenance.</p> <p>Resident #8's 8/12/13 Comprehensive Care Plan identified alteration in health status related to chronic bronchitis and shortness of breath. One of the plans and approaches was O2 therapy as ordered.</p> <p>Resident #8's 8/13 Physician's Orders (recapitulation) contained the 8/8/12 order O2 @ 2L/min prn to keep sats &gt;88% (at 2 liters per minute as needed to keep saturation levels greater than 88%).</p> <p>On 8/13/13 at 10:00 a.m. and on 8/14/13 at 10:05 a.m., Resident #8 was lying in bed and appeared to be asleep. The resident was receiving oxygen by way of nasal cannula (NC). The NC was connected to a concentrator next to resident's bed. On both of the observations the O2 flow rate was, "4" liters per minute.</p>	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/15/2013
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 640 NORTH EISENHOWER STREET MOSCOW, ID 83843		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 328	Continued From page 20  On 8/14/13 at 10:05 a.m., RN #6 accompanied the surveyor to observe the resident's O2 flow rate. The surveyor asked the RN what the flow rate was. The RN looked at the concentrator and confirmed, "4 liters per minute."  On 8/15/13 at 8:49 a.m., the surveyor informed RN #2 of the observations. The RN said she would check into it.  On 8/15/13 at 5:10 p.m., the Administrator was informed of the finding. The facility did not provide any additional information that resolved the finding.	F 328			
F 329 SS=E	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329	F 329 SS=E  1. a. Resident # 1 was referred to his physician for review. Daily sleep monitor was initiated. b. Resident #6 was referred to her physician for review. Daily sleep monitor was initiated. c. Resident #11 was referred to her physician for review and a GDR was obtained for Zyprexa 8/15/2013. Care plan has been updated to address behaviors. d. Resident #2 was referred to her physician for review. Daily sleep monitor was initiated and care plan was updated.  2. All residents receiving psychoactive meds have the potential to be affected. All residents on psychoactive meds will be reviewed to ensure proper documentation and/or GDRs.  3. GDR Committee will review sleep monitors, behavior documentation, and psychoactive medication use monthly and make recommendations. GDR committee will be educated on the new process.  4. Audits will be completed Monthly X 3 months, Quarterly X 2. All results will be monitored by DNS or designee and reported to QA/CQI for further monitoring and modification.  5. Compliance on or before Sept. 19, 2013	9/19/2013	

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	Continued From page 21 drugs.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to provide gradual dose reductions (GDR) for antipsychotic and hypnotic medications, failed to provide justification for multiple antidepressant use, and failed to provide sleep and behavioral monitoring. This affected 4 of 13 (#'s 1, 2, 6, and 11) sampled residents. This failed practice had the potential to cause harm to residents who received medications for depression (#2), sleep disturbances (#1, 2 and 6), and dementia with delusions (#11) when they were given medications they may not have been needed. Findings include:  1. Resident #1 was admitted to the facility on 9/4/12 with diagnoses of Impetigo and pressure ulcer to the buttock.  Resident #1's 7/1/13 recapitulated Physician's Orders documented in part: "9/4/12 Insomnia" was located above the order for the medication below: "02/13/13-Estazolam 0.5 mg PO Q HS" The resident's MARs documented the Estazolam was given nightly between 3/1/13 and 8/13/13.  A "FAX Communication to Physician" form dated 2/8/13 from the pharmacist regarding Resident #1 documented in part: "[Resident #1's name] has been on Estazolam 0.5 mg hs for insomnia since	F 329			

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 22</p> <p>September 2012. He is due for a dose reduction or your assessment that he still continues to need the hypnotic. Please advise." The response by Physician was to: "continue at current dose" and was signed and dated by the physician on 2/13/13.</p> <p>Resident #1's 3/2013 MAR documented in part: Page 3-"3/14/13 - 3/20/13 Sleep Monitor" documented Resident #1 did not sleep during the day, slept 2 hours during the evening and slept 7-8 hours at night. Note: The sleep monitor was for only 7 days during the month of March and Resident #1 slept an average of 9-10 hours daily.</p> <p>Resident #1's 7/2013 MAR documented in part: Page 3 - "7/29/13 - 7 day sleep monitor" documented Resident #1 slept 2 hours during the day on 7/29/13 (no hours were recorded for evenings or nights), and 9 hours a day on 7/30/13 &amp; 7/31/13.</p> <p>Resident #1's 8/2013 MAR documented in part: Page 3- "8/1/13-8/4/13 [4 days] Sleep Monitor" documented Resident #1 did not sleep during the day, slept an average of 3 hours in evening and 4-6 hours during the night. Resident #1 slept an average of 7 to 9 hours daily.</p> <p>A "FAX Communication to Physician" form dated 7/31/13 from a facility RN regarding Resident #1 documented in part: [Resident #1's name] has been on Estazolam 0.5 mg po QHS for Insomnia since admission. He still has nights when he does not sleep well with c/o [complaints of] itching skin and burning feet....Do you want to add anything to his MAR or consider changing his sleeping pill?" The response by Physician was: "no changes,</p>	F 329			

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 23 treatment adequate 07/31/2013"</p> <p>On 8/14/13 at 2:30 pm the Administrator and DON were interviewed regarding the lack of sleep monitoring and justification of continued use for the Estazolam given to Resident #1 for insomnia. The Administrator said the sleep monitoring was performed for a 7 day period every quarter through out the year.</p> <p>The Administrator provided a 3/13/13 "Psychopharmacological Medications and Sedative/Hypnotics Tracking Tool" which documented in part: Estazolam 0.5 mg po q hs was initiated on 9/4/12 for the diagnosis of insomnia. The tool documented the date of the last dose reduction was 12/12/12 and a "comment" on the form was to "ask for GDR for Estazolam."</p> <p>The Administrator also provided a 12/12/12 "Psychopharmacological Medications and Sedative/Hypnotics Tracking Tool" which documented Resident #1 had a order for Estazolam 0.5mg po qhs and Estazolam 0.5-1mg po q 4 hrs prn. The tool documented "DC PRN dose of Estazolam for non use x 60 days."</p> <p>The tracking tools documented the discontinuation of a hypnotic due to non use was considered a GDR. However, if Resident #1 did not use the medication it would not be considered a reduction of the medication.</p> <p>2. Resident # 6 was admitted to the facility on 5/24/12 with diagnoses of cellulitis, diabetes mellitus, congestive heart failure, and chronic kidney Failure.</p>	F 329		

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 24</p> <p>Resident #6's 8/1/13 recapitulated Physician's Orders documented in part: "Insomnia, Oxazepam 10 MG PO Q HS."</p> <p>Resident #6's 6/2013 TAR documented in part: "Sleep Monitor x 10 D [days]" documented 8 hours of sleep on 6/1/13, 9 hours on 6/2/13, and 10 hours of sleep on 6/3/13. Hand written on the sleep monitor is "Auto DC [discontinue]" and no other hours of sleep were recorded. Note: Only 3 days of sleep monitoring was recorded in June.</p> <p>Resident #6's 8/2013 MAR documented in part: "Oxazepam 10 MG Q HS."</p> <p>Resident #6's 8/2013 TAR did not document any hours of sleep for 8/1/13 - 8/12/13.</p> <p>Resident #6's "Consultants Progress Notes" from the pharmacist documented in part: "5/11/13 Rev[iew] of psych[oactive] meds [medications]...Oxazepam 10 mg hs insomnia 10/1/12, GDR requested 3/13 [3/13/13] MD decline..." "8/10/13 Rev of meds, psych... Oxazepam 10 mg hs insomnia 6/14/13" The pharmacist documented the MD declined a GDR on 3/13/13 and 6/14/13.</p> <p>A "FAX Communication to Physician" dated 2/8/13 documented in part: "[Resident #6] has been on oxazepam 10 mg po hs for insomnia since admission. She is due for a dose reduction or your assessment that she still continues to need the hypnotic. Please advise. Thank you." The response by physician was, "PT (patient) is stable on current regimen. Alternative meds or lower doses have not been effective. Please cont</p>	F 329			

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 25 (continue) current dose." Note: No GDR or adequate justification for continued use of Oxazepam was provided. No additional information related to alternative medications or lower doses was included.</p> <p>A "FAX Communication to Physician" dated 6/13/13 documented in part: "[Resident #6's name] has been on Oxazepam 10 mg PO QHS since admit. She is due for either a dosage reduction or justification for continued use. Could you please advise us on continued use?" The response by physician was, "Please continue as needed use of Oxazepam for insomnia." No justification was provided for the continued use of Oxazepam.</p> <p>On 8/14/13 at 2:30 pm the Administrator and DON were interviewed regarding the lack of sleep monitoring and the lack of justification for continued use of the Oxazepam for Resident #6. The Administrator said the sleep monitoring was performed for a 7 day period every quarter throughout the year. No additional information was provided which resolved the issue.</p> <p>3. Resident #11 was admitted to the facility on 2/16/11 with diagnoses of femur fracture, vascular dementia with delusions, psychosis, and depression.</p> <p>Resident #11's 8/1/13 recapitulated "Physicians Orders" documented in part: - "10/03/11 Zyprexa (Olanzapine) 5 mg PO Q HS" for Vascular Dementia with delusions , - "11/14/11 Depakote 250 MG PO BID" for Vascular Dementia with delusions, and - "12/22/12 Fluoxetine 10 MG PO Q AM" for Depressive Disorder</p>	F 329			

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 26</p> <p>Resident #11's 8/1/13 MAR documented in part: -Zyprexa (Olanzapine) 5 MG PO Q HS -Depakote 250 MG PO BID -Fluoxetine 10 MG PO Q AM Note: No behavior monitoring for delusions was found in Resident #11's medical record.</p> <p>Physicians Progress Notes from Resident #11's her primary physician, dated 7/6/13 documented in part: "2. Dementia-stable. Current medication are proper for her."</p> <p>A "FAX Communication to Physician" dated and signed by the pharmacist on 8/10/13, documented in part: "[Resident #11's name] has been on Zyprexa 5 mg hs and Depakote 250 mg bid for dementia with delusions since autumn of 2011. Nurses have reported no hallucinations since May and note no impulsive behaviors. Would you like to attempt a gradual dose reduction of one of these medications to see if she still requires both at current doses?" There was no response from the physician found in the resident's medical record regarding the gradual dose reduction. Note: The pharmacist did not address the "Black Box Warning" for the Depakote and Zyprexa with the physician.</p> <p>On 8/14/13 at 2:30 pm the Administrator and DON were interviewed regarding the lack of behavior monitoring and the lack of justification for continued use or a GDR for Resident #11's antidepressant (Fluoxetine), antipsychotic (Zyprexa), and anticonvulsant medication (Depakote) that was prescribed for the resident. The Administrator provided a "Psychopharmacological Medications And</p>	F 329			

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 27</p> <p>Sedative/Hypnotics Tracking Tool" form, dated 6/12/13 for Resident #11. The form documented in part:</p> <ul style="list-style-type: none"> <li>-Depression Disorder, Prozac, antidepressant, 10 mg po Q am, 12-22-12</li> <li>-Vascular Dementia with, Zyprexa, antipsychotic, 5 mg q hs, 2-16-11</li> <li>-Delusions, Depakote, antipsychotic, 250 mg po bid, 11-14-11</li> </ul> <p>"Comments were documented in part: "Behaviors haven't worsened since addition of Prozac. HX: dc'd [discontinued] Haldol 3/4/11; will request a GDR/Justification for continued use."</p> <p>The next request for a GDR in the resident's medical record was 8/10/13, requested from the Pharmacist. The Administrator provided Interdisciplinary Progress Notes dated 3/18/13 to 8/14/13 for the behavior monitoring documentation. However, the Interdisciplinary Progress Notes did not address any behavior monitoring for Resident #11.</p> <p>Again on 8/15/13 at 3:35pm the Administrator and DON were informed of the medication issues. No documentation or information was provided which resolved the issues.</p> <p>4. Resident #2 was admitted to the facility on 6/27/11 with diagnoses of persistent mental disorder, dementia, Alzheimer's disease, depressive disorder and insomnia unspecified.</p> <p>The most recent quarterly MDS, dated 7/24/13, documented the resident:</p> <ul style="list-style-type: none"> <li>* was moderately impaired with cognition BIMS = 9,</li> <li>* required little to no assistance with transfers, ambulation, dressing, eating, toileting, personal</li> </ul>	F 329		

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 28</p> <p>hygiene, * was always continent of bowel and bladder, * did not have pain issues, * did not have problems with, "Trouble falling or staying asleep, or sleeping to much" or "Feeling tired or having little energy."</p> <p>The August 2013 physician's recapitulation orders documented the resident to have, Lexapro 20 mg tablet orally each morning for depression (started 5/21/12), Trazodone 50 mg orally at bedtime for insomnia and may have Trazodone 50 mg 1/2 tablet orally as needed one time at night for occasional restlessness (started 1/12/13).</p> <p>The most recent care plan, dated 7/31/13, did not document any problems with "insomnia" and did no identify that medications or alternative interventions were used to treat the condition.</p> <p>The facility monitored the resident's sleep for 10 days in January 2013, 8 days in February 2013 and 7 days in May 2013. The documentation showed the following: * January 2013, Nights the resident slept 5 to 6 hours, days the resident slept 3 to 4 hours and evenings the resident slept 2, 3 and 5 hours. * February 2013, Nights the resident slept 5, 6 and 7 hours, days the resident slept 3, 4 and 5 hours and evenings the resident slept 3, 4 and 5 hours. * May 2013, Nights the resident slept 7 hours, days the resident slept 3 to 4 hours and evenings the resident slept 2, 3 and 4 hours.</p> <p>The resident was observed during the survey to be in her room all the time. When the resident was checked on 8/12/13 at 4:00 p.m., 8/13/13 at 7:38 a.m., 8/13/13 at 10:40 a.m., and on 8/13/13</p>	F 329		

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	Continued From page 29 at 2:15 p.m. the resident was observed to be in bed either with the covers over her head or her eye mask in place resting.  The Administrator was interviewed, on 8/13/13 at 3:15 p.m. about the resident's use of Lexapro and Trazodone. The Administrator was advised that: * The resident had not had a dose reduction for the Trazodone, and the resident was sleeping on days and afternoons along with nights, * There was no justification for use of two antidepressants, * There was no monitoring since May 2013 of the resident's sleep patterns, * There was no care plan, which included non-pharmacological interventions, for the resident's problem of insomnia.	F 329			
F 371 SS=F	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  This REQUIREMENT is not met as evidenced by: Based on observation, dish machine temperature log review, the facility's Policy and Procedure for Dishwashing Sanitation and staff interview, it was determined the facility failed to ensure the ware (dish) washing machine	F 371	F 371 SS=F  1. The booster tank for the dishwashing machine was reset on 8/15/2013. Chemical sanitizing was removed.  2 All residents have the potential to be affected by this process.  3. Dietary department orientation will include dishwashing machine temperature monitoring and will be included in annual in-service. All dietary staff were re-educated on techniques and monitoring the dishwashing temperatures.  3. Temperatures will be audited daily X 1 week. Weekly X3 weeks, Monthly X 2. All results will be monitored by ESD/designee and reported to QA/CQI for further monitoring and modification.  5. Compliance on or before Sept. 19, 2013	9/19/2013	

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 30</p> <p>sanitized equipment and dishes used in the preparation and service of food for the residents. This affected 13 of 13 sampled residents (#s 1-13) and had the potential to affect all residents who dined in the facility. This practice created the potential for contamination of food contact surfaces and exposed residents to potential sources of disease causing pathogens. Findings included:</p> <p>The facility's Policy and Procedure for Dishwashing Sanitation, revised March 2009, documented in part, "Check temperature for proper temperature for wash, rinse cycle. (If chemical use, check level of chemicals with test strips at least once each meal service.) If temperatures/chemicals are outside acceptable parameters, staff will notify DDS Director of Dietary Services or maintenance before proceeding with dishwashing. The ADC conveyor [type of machine] supports both methods of sanitizing, and NSF lists it as a dual sanitizer. The final rinse manifold will accomplish the task of applying chemical sprays or high temperature sprays with the same water consumption rates. This difference is in the chemical dispenser application (minimum 50 [ppm] chlorine) or the boosted incoming hot water (minimum 180 [*F]) for final rinse."</p> <p>On 8/12/13 at 5:30 p.m. during the initial tour of the facility's kitchen, the DDS said the ware washing machine sanitized dishes and equipment by the use of a chemical sanitizing process. The DDS also stated the machine had a hot water booster for back up sanitizing.</p> <p>On 8/15/13 at 11:00 a.m. the sanitation cycle of the ware washing machine was evaluated. The</p>	F 371			

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	<p>Continued From page 31</p> <p>machine was started and run through four full cycles prior to evaluation of the machine. The Final Rinse gauge registered 190 degrees Fahrenheit (*F).</p> <p>* Then, using a cup, the DDS obtained water from the water well of the machine. The DDS placed a chemical test strip in the cup of water. The test strip did not change color.</p> <p>* Then the DDS placed a thermolabel on a dish, placed the dish on a ware washing tray, and ran the tray through the machine. The thermolabel came off the dish in the machine, fell into the water well, and was not retrievable. The DDS repeated this process and again the thermolabel came off in the machine and was not retrievable.</p> <p>* Then the DDS placed a thermometer on a ware washing tray, ran the tray through the machine. The thermometer read, "118 *F." At this point the DDS stated, "This means I need to call the maintenance man before they [dietary staff] run dishes through [the ware washing machine]."</p> <p>- At 11:15 a.m. the surveyor placed a thermolabel on a dish. The dish was placed on a ware washing tray and run through the machine. The thermolabel did not change color from grey to black to indicate the water temperature of the final rinse was at least 160 *F.</p> <p>- At 11:30 a.m., the DDS provided the dietitian surveyor with a copy of a form titled "Dish Machine Temperature Log Chemical Sanitizing." The form contained in the far left column the days of the month. There were also columns for Morning, Noon and Evening and subcolumns under each Morning, Noon, and Evening titled: Wash, Chemical Concentration and Final Rinse. The DDS and surveyor discussed the documentation on the form. For example, under the column Morning: subcolumn, Chemical</p>	F 371		

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	<p>Continued From page 32</p> <p>Concentration, handwritten entries ranged from 100 to 130, to 135, to 145 parts per million (ppm). The surveyor asked how the determination was made that the Chemical Concentration was at 145, 135 and 130 as the chemical test strip values were 50, 100 and 200 ppm. The DDS said, "I will have to check." Under the subcolumn Final Rinse, handwritten entries ranged from 140 to 190 *F. The surveyor asked the DDS where these entries were obtained from. The DDS stated, "From the gauge on the machine." The surveyor asked, how did dietary staff evaluate to ensure the gauge was working properly? The DDS stated, "[Name of company that services the machine] comes in about once a month." The surveyor asked if dietary staff performed any type of evaluation of the Final Rinse to ensure the machine actually heated to 160 *F during the Final Rinse which would indicate the gauge was accurate. The DDS moved her head in a side to side movement indicating no.</p> <p>On 8/15/13 at 1:02 p.m., the DDS and Dietary Aide #8 (DA #8) and surveyor discussed the documentation of the Dish Machine Temperature Log Chemical Sanitizing form. The DDS stated, "On 8/1/13 the chemical concentration of 145 was from one of the temperature gauges on the machine, not the chemical test strip ppm. The chemical is chlorine."</p> <p>On 8/15/13 at 1:18 p.m., the DDS brought a wet Dishwasher Temperature Test Strip to the surveyor that indicated the machine's Final Rinse was evaluated and reached the minimum 160 *F. The DDS stated, "The maintenance man came in, unlocked a box on the top of the machine, pressed a switch and said that is what the problem was. I then ran this hot water test strip</p>	F 371		

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/15/2013
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 640 NORTH EISENHOWER STREET MOSCOW, ID 83843	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 33 through the machine and the test strip turned color for the sanitizing temperature of 160 *F."  The 2009 FDA Food Code, Chapter 4, Equipment, Utensils, and Linens, 4-7 Sanitization of Equipment and Utensils, subpart 4-703.11 Hot Water and Chemical, indicated, "...After being cleaned, Equipment Food-contact surfaces and Utensils shall be sanitized in: ...(B) Hot water mechanical operations by being cycled through...and achieving a utensil surface temperature of 71 [degrees Celsius] (160 *F) as measured by an irreversible registering temperature indicator; or (C) Chemical...operations...(2)...chlorine solution of 50 [ppm]..."  On 8/15/13 at 5:10 p.m., the Administrator was informed of the finding. The facility did not provide any additional information related to the finding.	F 371		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  The facility must employ or obtain the services of	F 425	F 425 SS=E  1. Residents #5, 9, 18, 19, 20, 21, 22, 23, 24 & 25 were reviewed by the Consulting Pharmacist, Dispensing Pharmacist and DNS on 8/23/132.  2. All residents with med errors have the potential to be affected. Med errors for the last three months were reviewed.  3. All med errors will be logged by the DNS. Guidelines for receiving meds were created, which include consulting pharmacy review. LNs will be educated on the guidelines.  3. 4. Audits will be completed Monthly X 3 months, Quarterly X 2. All results will be monitored by DNS/designee and reported to QA/CQI for further monitoring and modification.  5. Compliance on or before Sept. 19, 2013	9/19/2013

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>
--	--

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

F 425	<p>Continued From page 34</p> <p>a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of incident reports and staff interview, it was determined that the facility's consulting pharmacist was not involved in ensuring the medications packaged by the contract pharmacy were accurate and/or contained the correct medications for 2 of 15 (#s 5 &amp; 9) sampled residents and 8 (#s 18, 19, 20, 21, 22, 23, 24 &amp; 25) random residents. The errors had the potential to harm residents because they could receive the wrong medication or medication dosage. Findings include:</p> <p>1. Review of incident reports revealed that the facility received the wrong medications for 10 residents between 3/19 and 7/23/13. The following issues were reported:</p> <p>a. Resident #18 on March 19, 2013 was to receive "Depakote 250 mg two capsules." When the pill cassette for the designated administration time was reviewed it was discovered that the pharmacy had packaged 125 mg capsules in the container. The resident received the lower dosage but did not have any seizure activity as a result of the wrong medication.</p> <p>b. Resident #19 on April 1, 2013 had an order for "Cipro 500 mg po two times a day for 7 days." The pharmacy cassette was labeled Cipro 250 mg. After investigation it was found the capsules</p>	F 425		
-------	---	-------	--	--

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 425	<p>Continued From page 35</p> <p>were actually Cipro 500 mg capsules and the cassette was mislabeled. The resident did not receive the medication.</p> <p>c. Resident #5 on May 31, 2013 was to receive Prednisone 60 mg orally. When the cassette was inspected there were only 30 mg present. Instead of 3 - 20 mg tablets there were 3 - 10 mg tablets. The resident received the lower dose and had some mild respiratory wheezing later in the day that required an Albuterol treatment to resolve.</p> <p>d. Resident #20 on May 7, 8, and 9, 2013 was to receive Flomax in the evenings. The resident did not receive the Flomax because the pharmacy packaged the medication in a morning cassette. The resident did not get the medication.</p> <p>e. Resident #21 on May 7 &amp; 8, 2013 was to receive Seroquel 50 mg at bedtime. The evening pill cassette was found to have 25 mg capsules instead of 50 mg. The resident received half of the ordered strength. No adverse consequences were noted.</p> <p>f. Resident #22 on June 8, 9, 10, &amp; 11, 2013 was to receive Lyrica. It was discovered on 6/11/2013 that the resident had been receiving a wrong ordered dosage. The incident report does not specify the dosage amounts but it is documented the resident received the medication two times a day starting June 8, 2013.</p> <p>g. Resident #23 on July 3, 2013 was to receive Remeron 30 mg at bedtime. The pharmacy packaged the medications in a morning and an evening cassette. The resident received one dose of the medication in the morning. There were no adverse consequences from getting two doses</p>	F 425			

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 425	<p>Continued From page 36 that day.</p> <p>h. Resident #9 on July 6, 7, 8, 9, 10, 11, 12, 13 and 14, 2013 was to receive Losartan 50 mg each day. The cassette had 25 mg tablets packaged. The resident's blood pressure was monitored and no adverse effects were found.</p> <p>i. Resident #24 on July 13 &amp; 14, 2013 received Trazodone 50 mg 1/2 tablet. The resident did not have an order for Trazodone. The cassette was packaged with the resident's name on it but she was not supposed to receive it.</p> <p>j. Resident #25 on July 23, 2013 was to receive Amlodipine 10 mg. The pharmacy packaged 5 mg tablets in the cassette. The resident received half of the prescribed dosage. The resident did not have any adverse consequences from the lower dose.</p> <p>On 8/14/13 at 10:30 a.m. the DON was interviewed about the errors that were found in the incident reports. When questioned about the involvement of the consultant pharmacist, it was discovered the pharmacist had not been involved in seeking a correction to the issue. The pharmacist was not involved in reviewing medication errors.</p> <p>On 8/14/13 at 1:10 p.m. the consultant pharmacist was interviewed by phone and indicated that she was not associated with the pharmacy that supplied the medications so had not looked at the issues. The pharmacist further indicated that she would be more involved and would, along with the DON, start to monitor the pharmacy errors. She would also initiate dialogue with the pharmacy supplier.</p>	F 425			

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/15/2013
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 640 NORTH EISENHOWER STREET MOSCOW, ID 83843		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 425	Continued From page 37	F 425			
F 498 SS=D	<p>The Administrator and DON were informed on 8/15/13 at 2:00 p.m. The DON had developed a plan of correction to assure the pharmacist and pharmacy issues would be evaluated and packaging errors resolved.</p> <p>483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS</p> <p>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of the facility's Procedure for Mechanical Lift, it was determined the facility failed to ensure nurse aides demonstrated competency in skills and techniques necessary to care for residents. CNA #9 and #10 transferred Resident #11 using a standing lift without applying the shin straps. This failed practice created the potential for harm should the resident's legs buckle and she slip from the standing position. This affected 1 of 1 (#11) sampled residents observed for a mechanical lift transfer. Findings included:</p> <p>Resident #11 was admitted to the facility on 2/16/11 with diagnoses of femur fracture, dementia, psychosis, and depression.</p> <p>Resident #11's 8/12/13 Care Plan documented a "Problems/needs/concerns" in part: -"Alteration in mobility R/T HX of R hip Fx E/B</p>	F 498	<p>F 498 SS=D</p> <ol style="list-style-type: none"> <li>1. The leg strap is being used on Resident #11 when transferring with the sit-to-stand lift.</li> <li>2. All residents using the sit-to-stand lift have the potential to be affected. Residents care planned for the sit-to-stand lift will be audited to ensure the let strap is being used.</li> <li>3. The leg strap will be used for all sit-to-stand lift transfers. Education will be provided prior to CNA floor orientation and annually. Nursing staff will be educated on sit-to-stand lift usage and perform return demonstrations.</li> <li>4. Audits will be completed weekly X 4 weeks, then monthly X 2. All results will be monitored by DNS/designee and reported to QA/CQI for further monitoring and modification.</li> <li>5. Compliance on or before Sept. 19, 2013</li> </ol>	9/19/2013	

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>	
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 498	<p>Continued From page 38</p> <p>[related to history of right hip fracture as evidenced by] inability to independently transfer or ambulate." A long/short term goal was documented as, "Will maintain ability to use sit to stand lift..." Plans and approaches were documented as, "Transfers: sit to stand lift with one person assist"</p> <p>Observations of Resident #11 being transferred were:</p> <p>* On 8/14/13 at 1:10 pm in the Nurse's Station Lounge, CNA #9 was observed transferring Resident #11 from her manual wheelchair into a recliner using a standing lift and without applying the shin straps.</p> <p>*On 8/13/13 at 8:50 a.m., CNA #9 was observed to use a sit-to-stand lift and transferred Resident #11 from her wheelchair to a recliner in the Nurse's Station Lounge. The CNA failed to put the safety strap around the legs of the resident during the transfer.</p> <p>*On 8/14/13 at 2:35 p.m., CNA #10 was observed to use a sit-to-stand lift to transfer Resident #11 from her wheelchair to a recliner in the Nurse's Station Lounge. The CNA failed to use the shin safety strap during the transfer.</p> <p>The facility provided a Procedure for "Mechanical Lift" that documented in part: Procedure: Surface to Surface with Sit-To-Stand "7. Standing next to the resident, position the sit-to-stand in front of resident. Direct/assist resident to place feet squarely on the footrest and advance the sit-to-stand until shins rest against the shin pad. Fasten the shin straps to keep shins and feet in place."</p>	F 498		

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/15/2013
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 640 NORTH EISENHOWER STREET MOSCOW, ID 83843		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 498	Continued From page 39 On 8/15/13 at 3:35 pm, the Administrator and DON were informed of the observation of Resident #11 being transferred with the standing lift and without the shin straps applied. No documentation or information was provided that resolved the issue.	F 498			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on observations, review of medical records and staff interview, it was determined the facility failed to maintain accurate documentation of services in accordance with accepted professional standards. This affected 1 of 15 (#5) sampled residents. This resulted in the potential for a lack of sufficient information being present on which to base treatment decisions. Findings include:  The comprehensive care plan for Resident #5 dated 6/11/13 stated the problem of: "Alteration in	F 514	F 514 SS=D  1. Ted hose were obtained for resident #5. 2. All residents with orders for ted hose have the potential to be affected. All residents with ted hose will be audited for accurate documentation. 3. LNs will perform direct observation of ted hose prior to documentation. LNs will be re-educated on process. 4. Ted hose documentation will be audited weekly x 4. All results will be monitored by the DNS/designee and reported to QA/CQI for further monitoring and modification. 5. Compliance on or before Sept. 19, 2013	9/19/2013	

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 40</p> <p>cardiac output r/t (related to) htn (hypertension), hyperlipidemia m/b (manifested by) increased bp (blood pressure), activity intolerance and edema." The care plan and the recapitulated physician's orders signed on 7/31/13 stated that Resident # 5 was to have, "knee high TED hose on AM and off at HS."</p> <p>On 8/13/13 at 8:15 a.m. during breakfast observation, the surveyor noticed Resident # 5 had regular socks on. This same observation was repeated on 8/14 and 8/15. When asked about the socks on 8/15/13 at breakfast time, CNA's #3 response was, "the night shift dresses her in the mornings before I get here."</p> <p>The MAR documented that the TED hose were on the morning and off at night daily from 8/01/13 to 8/15/13. During an interview with RN #5 and CNA #3 on 8/15/13 after breakfast, CNA #3 stated that she spoke with the night shift and was told the TED hose had been missing for the last 2 weeks and that is why they were not on the resident. RN #5 stated that no one had made her aware of this.</p> <p>RN #5 did not state why she documented care that was not observed or provided.</p> <p>The Administrator and DON were notified of this information on 08/15/13 at 5 p.m. No additional information was provided.</p>	F 514			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001510</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>
---	--

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

C 000	16.03.02 INITIAL COMMENTS  The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the state Licensure survey of your facility.  The surveyors conducting the survey were:  Karen Marshall, MS, RD, LD Team Coordinator Arnold Rosling, RN, BSN, QMRP Debra Bernamonti, RN Karla Gerleve, RN	C 000		
C 119	02.100.03,c,iii Informed of Medical Condition by Physician  iii. Is fully informed, by a physician, of his medical condition unless medically contraindicated (as documented, by a physician, in his medical record), and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research; This Rule is not met as evidenced by: Refer to F tag 155 and the right to refuse treatment and participate in care decisions.	C 119	C119 See F 155	
C 159	02.100.09 RECORD OF PTNT/RSDNT PERSONAL VALUABLES  09. Record of Patient's/Resident's Personal Valuables. An inventory and proper accounting shall be kept for all valuables entrusted to the	C 159	C 159 See F 204	9/19/2013

**RECEIVED**  
**SEP 10 2013**  
**FACILITY STANDARDS**

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

*[Handwritten Signature]*

TITLE

*[Handwritten Title]*

(X6) DATE

9-9-13

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001510</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 159	Continued From page 1  facility for safekeeping. The status of the inventory shall be available to the patient/resident, his conservator, guardian, or representative for review upon request. This Rule is not met as evidenced by: Please refer to F204 as it related to ensuring discharged residents' belonging were accounted for.	C 159		
C 175	02.100,12,f Immediate Investigation of Incident/Injury  f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Refer to F225 as it relates to investigating an injury of unknown origin.	C 175	C175 See F 225	
C 221	02.105,a,xi Special Needs of Population Served  xi. Special needs of the population served; and This Rule is not met as evidenced by: Please refer to F498 regarding CNA improper use of a standing lift.	C 221	C 221 See F 498	
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 Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards	C 325	C325 See F 371	9/19/2013

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001510</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 325	Continued From page 2 for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Please refer to F371 as it related to the sanitizing final rinse of the ware washing machine.	C 325		
C 362	02.108,07,a Interior Surfaces Kept Clean & Sanitary  a. Floors, walls, ceilings, and other interior surfaces, equipment and furnishing shall be kept clean, and shall be cleaned in a sanitary manner. This Rule is not met as evidenced by: Refer to F-tag 252 as it relates to a clean comfortable environment.	C 362	C 362 See F <del>371</del> <b>F252</b>	
C 778	02.200,03,a PATIENT/RESIDENT CARE  03. Patient/Resident Care.  a. A patient/resident plan of care shall be developed in writing, upon admission of the patient/resident, which shall be: This Rule is not met as evidenced by: Refer to F309 as it relates to care planning	C 778	C 778 See F 309	
C 779	02.200,03,a,i Developed from Nursing Assessment  i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Please refer to F272 as it related to not assessing positioning devices as safe for the residents to use.	C 779	C 779 See F 272	9/19/2013

*per Administrator  
via email on 9/20/13  
at 2:29 PM, C362 should  
refer to F252.  
BRAD PERRY, LSW*

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001510</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 781	Continued From page 3	C 781		
C 781	02.200,03,a,iii Written Plan, Goals, and Actions  iii. Written to include care to be given, goals to be accomplished, actions necessary to attain the goals and which service is responsible for each element of care; This Rule is not met as evidenced by: Please refer to F280 as it related to not care planning delirium.	C 781	C 781 See F 280	
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: Refer to F tag 309 as it relates to meeting resident needs.	C 784	C 784 See F 309	
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: Please refer to F328 as it related to not following physician's orders for the administration of oxygen therapy. Please refer to F 281 for administration of expired medication.	C 788	C 788 See F 328 and F 281	
				9/19/2013

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001510</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>
---	--

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

C 797	Continued From page 4	C 797		
C 797	<p>02.200,03,c Documentation of Nursing Assessments</p> <p>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: Refer to F329 as it relates to lack of documentation on the resident's medical record for using medications.</p>	C 797	C 797 See F 329	
C 832	<p>02.201,02,f Labeling of Medications/Containers</p> <p>f. All medications shall be labeled with the original prescription legend including the name and address of the pharmacy, patient's/resident's name, physician's name, prescription number, original date and refill date, dosage unit, number of dosage units, and instructions for use and drug name. (Exception: See Unit Dose System.)</p> <p>This Rule is not met as evidenced by: Refer to F425 as it relates to correct labeling of</p>	C 832	C 832 See F 425	9/19/2013

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001510</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 832	Continued From page 5 medications in the package.	C 832		
C 835	<p>02.201,02,i Meds in Possession of Resident Limitations</p> <p>i. No medication shall be in the possession of the patient/resident unless specifically ordered by the physician on the patient's/resident's medical record, and in no case shall exceed two (2) units of dosage. All such medications shall be individually packaged by the pharmacist in units of dose, labeled with the patient's/resident's name, unit of dose, and date of distribution. The charge nurse shall maintain an inventory of these drugs on the patient's/resident's medical record.</p> <p>This Rule is not met as evidenced by: Please refer to F176 as it related to ensuring residents who self administered medications were assessed by the Interdisciplinary Team (IDT) and appropriate annotations were made in the resident's care plan.</p>	C 835	<p>C 835 See F 176</p>	
C 837	<p>02.201,02,k National Standards for Dispensing</p> <p>k. Drugs dispensed shall meet the standards established by the United States Pharmacopeia, the National Formulary, New Drugs, the Idaho Board of Pharmacy, and the U.S. Food and Drug Administration.</p> <p>This Rule is not met as evidenced by: Refer to F425 as it relates to standards of pharmacy related to correct labeling and dosage</p>	C 837	<p>C 837 See F 425</p>	9/19/2013

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001510</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/15/2013</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 837	Continued From page 6 identification.	C 837		
C 856	02.201,04,c Documentation of Use and Results  c. Reasons for administration of a PRN medication and the patient's/resident's response to the medication shall be documented in the nurse's notes.  This Rule is not met as evidenced by: Please refer to F329 in reference to lack of sleep and behavior monitoring and gradual dose reductions.	C 856	C 856 See F 329	
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 tag reference to accurate documentation.	C 881	C 881 See F 514	9/19/2013