



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

October 31, 2014

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

FILE COPY

Provider #: 135067

**RE:** Corrected copy of the October 9, 2014, Recertification, Complaint Investigation and State Licensure survey cover letter dated October 24, 2014

Dear Ms. Berg:

On **October 9, 2014**, a Recertification, Complaint Investigation 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. On **October 24, 2014**, your facility was sent a certified letter (7007 3020 0001 4038 9826) from our office notifying you of the results of that survey.

On October 24, 2014, 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 was sent to your facility, which required a Plan of Correction to be submitted to our office by November 5, 2014.

Enclosed is a **revised** copy of Statement of Deficiencies and Plan of Correction, Form

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**CMS-2567. The previous copy did not contain the scope/severity for the federal citations. In addition, it was discovered that the PoC and IDR submission dates were incorrect in the survey cover letter and that the survey cover letter did not list the remedy that will be recommended if substantial compliance is not achieved.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office by **November 6, 2014.**

**The revised copy of the Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form will become the statement of record.**

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

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

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effective date of the remedy when determining your target date for achieving compliance.

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

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 **November 13, 2014 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **November 13, 2014**. A change in the seriousness of the deficiencies on **November 13, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 13, 2014** includes the following:

Denial of payment for new admissions effective **January 9, 2015**. [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 **April 9, 2015**, 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, they will provide you with a separate formal notification of that determination.**

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. This request must be received by **November 6, 2014**, as stated in our previous letter; page 4. If your request for informal dispute resolution is received after **November 6, 2014**, the request will not be granted.

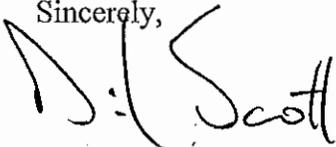
Jamie M. Berg, Administrator

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We apologize for any inconvenience this may have caused. Should you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, (208) 334-6626, fax (208) 364-1888.

Sincerely,

A handwritten signature in black ink that reads "David Scott". The signature is written in a cursive style with a large, stylized "D" and "S".

DAVID SCOTT, R.N., Supervisor  
Long Term Care

DS/dmj  
Enclosures

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

PRINTED: 10/31/2014  
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  C 10/09/2014
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 640 NORTH EISENHOWER STREET MOSCOW, ID 83843
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following are the results of the recertification and complaint survey for the facility. The team entered the facility on 10/5/14 and exited on 10/9/14. Members of the survey team were:</p> <p>Nina Sanderson, LSW, BSW - Team Coordinator Brad Perry, LSW, BSW Lauren Hoard, RN, BSN</p> <p>Survey Definitions:</p> <p>ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CAA = Care Area Assessment CHF = Congestive Heart Failure CM = Centimeters CNA = Certified Nurse Aide DON/DNS = Director of Nursing Services FDA = Food and Drug Administration LN = Licensed Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MD = Medical Doctor MDS = Minimum Data Set MG = Milligrams MRR = Medication Review Report TAR = Treatment Administration Record</p>	F 000	<p>Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations manual.</p>	
F 154 SS=D	<p>483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, &amp; TREATMENTS</p> <p>The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.</p> <p>The resident has the right to be fully informed in advance about care and treatment and of any</p>	F 154	<p>F tag 154 SS=D</p> <ol style="list-style-type: none"> <li>1. Resident # 9 - The Zyprexa black box warning, that residents with dementia are at higher risk of death due to cardiovascular disease and infections, was shared with resident/responsible party.</li> <li>2. All residents taking antipsychotic medications that have black box warnings have the potential to be affected by this practice.</li> <li>3. The QAPI process identified the lack of nurse education regarding sharing black box warnings with residents/responsible parties as the root cause of the practice. Permission forms for antipsychotic medications will now include black-box warnings.</li> <li>4. All licensed nurses were re-educated about process change to include black box warnings for antipsychotic medications.</li> <li>4. DNS or designee will audit records of residents using antipsychotic medication for education on the black box warning weekly x 4, then monthly x 3.</li> </ol> <p>All audit findings will be reported to QAPI committee monthly for further monitoring and modification.</p>	December 8, 2014

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>J. B. [Signature]</i>	TITLE  Administrator	(X6) DATE  12-4-14
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 NORTH EISENHOWER STREET MOSCOW, ID 83843</b>		
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F 154	<p>Continued From page 1</p> <p>changes in that care or treatment that may affect the resident's well-being.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to consider the risk identified in the black box warning for an antipsychotic medication. This was true for 1 of 4 residents (#9) sampled for antipsychotic medications. This created the potential for harm if residents or their representatives did not have adequate risk versus benefit information prior to starting an antipsychotic medication which could lead to adverse reactions and health decline. Findings included:</p> <p>1. Resident #9 who was older than 83 years was admitted to the facility on 2/16/11 with multiple diagnoses including vascular dementia with delusions and hypertension.</p> <p>The resident's Physician's Orders dated 9/19/14, documented, "Zyprexa tablet Give 1.25 mg by mouth one time a day related to Vascular Dementia with Delusions..." The October 2014 MAR documented the resident had received the medication as ordered.</p> <p>The resident's medical record contained a document titled Permission For Use of Psychopharmacological Medications and Sedative/Hypnotics and was signed by the resident's representative on 2/17/11. It contained potential risks and benefits, however, the document did not contain a warning of increased risk of death in the elderly for the antipsychotic.</p>	F 154			

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F 154	Continued From page 2 On 10/8/14 at 10:55 AM the DON was interviewed regarding the consent form. When asked if the resident's representative was informed of the risk of death with Resident #9's medication, she stated, "It's not on those older forms." She said the consent form had not been updated.	F 154	 <p>F tag 241 SS=D</p> <ol style="list-style-type: none"> <li>The staff member was re-educated on dignity issue of standing while assisting with dining. Resident #3 did not have any evidence of negative affect on their psychosocial well-being as evident by eating 26-50% of this meal with an intake of 120cc. This is consistent with her usual intake during this period of time.</li> <li>All residents needing dining assistance have the potential to be affected by this practice.</li> <li>The QAPI process identified root cause as being that dining room re-orientation had not been provided to non-nursing CNAs prior to their assisting in the dining room. The systemic change was to develop an orientation on resident dining needs that would be utilized prior to non-nursing CNAs assisting in the dining process in order to ensure there is no negative affect on the psychosocial well-being of residents. Non-nursing CNA staff will be educated on dining orientation.</li> <li>Dietary manager, DNS, or designee, will audit if staff members are standing while feeding residents daily x 5 day, weekly x3, and monthly x 2.</li> </ol> <p>All audit findings will be reported to QAPI committee meeting monthly for further monitoring and modification.</p>	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure dining assistance was provided to maintain or enhance each resident's dignity. This affected 1 of 12 (#3) sampled residents when a staff member stood while assisting Resident #3 with the lunch meal. Failure to promote the resident's dignity in dining created the potential for a negative effect on the resident's psychosocial well-being. Findings included:  Resident #3 was readmitted to the facility on 2/27/14 with multiple diagnoses which included senile dementia with delusional features and legal blindness.	F 241		

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F 241	Continued From page 3 The Care Plan for Resident #3 documented a focus, "The resident has nutritional problem R/T [related to] malise [sic] and fatigue, nausea with vomitting [sic] E/B [evidenced by] poor p.o. [by mouth] intake...", initiated on 1/17/14 and revised on 7/23/14. An intervention included, "Provide set up at meals, cue and extensive assist when needed...", initiated on 1/17/14 and revised on 10/2/14.  On 10/7/14 at 12:02 p.m., Resident #3 was seated in her wheelchair at the dining table, and the lunch meal had been served. The Health Information Manager (HIM) was observed to stand while providing a bite of food to the resident. The HIM provided the resident with a cup of coffee, assisted the resident with a drink and assisted with 2 more bites of food while standing.  On 10/7/14 at 1:13 p.m., the HIM was interviewed. The HIM said she was certified as a nursing assistant and had been working at an assisted living prior to working for the facility in September 2014. The HIM stated, "Usually we all sit down" to assist the residents with dining, but it depended on whether or not the staff member was going back and forth between residents.  On 10/7/14 at 1:24 p.m., the policy and procedure for assisting residents with dining was requested but not provided.  On 10/8/14 at 4:30 p.m., the Administrator and DON were informed of the dining concern. No further information or documentation was provided.	F 241			
F 242	483.15(b) SELF-DETERMINATION - RIGHT TO	F 242			

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F 242 SS=D	<p>Continued From page 4</p> <p><b>MAKE CHOICES</b></p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure meals provided met the resident's preference. This affected 1 of 12 (#5) sampled residents. The facility's failure to ensure a resident's meal choices were recognized created the potential for weight loss when her meal preferences were not honored. Findings included:</p> <p>Resident #5 was admitted to the facility on 3/12/13 with multiple diagnoses including paralysis agitans and dementia.</p> <p>The resident's quarterly MDS assessment dated 7/2/14, documented the resident was severely cognitively impaired with a BIMS of 7.</p> <p>On 10/7/14 at 12:10 PM, during the lunch meal, the resident had her meal in front of her which included a small bowl of cooked carrots. LN #1 offered the resident the carrots, but the resident told LN #1 she did not want them.</p> <p>The resident's meal card, reviewed on 10/7/14, documented dislikes, "No: Carrots..."</p>	F 242	<p>F tag 242 SS=D</p> <ol style="list-style-type: none"> <li>1. Resident #5 was re-assessed on food preferences. Care plan and dining card were updated. Staff did not follow dietary card.</li> <li>2. All residents have the potential to be affected by this practice.</li> <li>3. The QAPI process identified the root cause as being that the staff did not review the diet card prior to presenting the meal to the resident. The system change is that cook will review diet card prior to plating the food as well as staff reviewing the card prior to delivering food to ensure that the food served matches the diet preferences. Dietary and nursing staff were educated on process.</li> <li>4. Dietary Manager or designee will audit the plated food to ensure that preferences are being followed daily x 5, weekly x 3, monthly x 2. All audit findings will be reported to QAPI committee monthly for further monitoring and modification.</li> </ol>	December 8, 2014
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F 242	Continued From page 5 On 10/7/14 at 2:10 PM, LN #1 was interviewed about the carrots and she stated she had forgotten the resident did not like carrots at the time she offered them.  On 10/7/14 at 2:25 PM, the Dietary Manager was interviewed and was shown the meal card. When asked why the resident was served carrots, she stated, "I can ask the cook."  On 10/8/14 at 4:45 PM, the Administrator and DON were informed of the issue. No further information was provided by the facility.	F 242			
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and individual resident and staff interview, it was determined the facility failed to provide an ongoing program of activities to include: -Activities in the morning for residents with cognitive impairments; -Activities which were sufficient in length to allow residents to attend; and, -Activities based on 1 resident's preferences. This was true for 1 of 12 (#7) sampled residents and a number of other residents with cognitive impairments who did not reside in the Special Care Unit (SCU). The lack of activities had the	F 248	F tag 248 SS=E 1. Resident # 7 has been re-assessed for individualized activity programming to meet psycho-social needs. Care plan has been updated. 2. All cognitively impaired residents, identified by MD diagnosis, not on the SCU have potential to be affected. 3. The QAPI process identified the root cause of deficiency as a failure to identify on an activity calendar the activities for the cognitively impaired residents not living in the SCU. The system change was the development of an Activity calendar for cognitively impaired residents which is posted in activity office. Activity and Nursing staff has been informed of the additional Activity calendar and where it is posted. 4. Social Services or designee will audit the participation of the cognitively impaired residents in the activities offered weekly x 4 and monthly x 2. All audit findings will be reported to QAPI committee monthly for further monitoring and modification.	December 8, 2014	

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F 248	<p>Continued From page 6</p> <p>potential to create an atmosphere of boredom and foster an increase in negative behaviors, placing residents at risk for psychological harm. Findings included:</p> <p>1. The Activity Calendars for September and October 2014 were reviewed. The calendars lacked variety and/or an alternate schedule in the mornings for cognitively impaired residents who did not reside in the SCU.</p> <p>The September and October 2014 morning activities were: *9:30 AM-Exercise (Every day); *10:00 AM-Refreshments and Devotions (Every day); *10:30 AM-News (Every day); and, *12:45 PM-Visits (Every day).</p> <p>a. The following observations were made in the Activity Area of the facility: *10/6/14 9:35 AM-11 residents were in wheelchairs or lounge chairs in the Activity Area with 4 of the residents in view of the turned on television. The 'Exercise' activity was being conducted in the Sun Lounge, down the hallway from the Activity Area. Note: The Activity Area room was L-shaped with a television in the lower part of the L in the corner. The television was not visible to all residents sitting in the top section of the long part of the L-shaped room; 1:12 PM-8 residents were in wheelchairs or lounge chairs in the Activity Area with no activity in progress; *10/7/14 10:40 AM-8 out of 11 residents who were in wheelchairs or lounge chairs in the Activity Area were asleep. The 'News' activity was being</p>	F 248		

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F 248	<p>Continued From page 7</p> <p>conducted in the Sun Lounge down the hallway from the Activity Area; 11:20 AM-6 out of 9 residents who were in wheelchairs or lounge chairs in the Activity Area were asleep. One resident rocked back and forth in their wheelchair, another resident was staring at the nurses station, and a different resident was glaring at other residents in the Activity Area; 1:15 PM-5 out of 9 residents who were in wheelchairs or lounge chairs in the Activity Area were asleep.</p> <p>b. The following observations were made immediately following the scheduled activity of 'News' which occurred every day at 10:30 AM: *10/7/14 at 10:43 AM-5 of the 5 residents who attended the 'News' activity began to leave the Sun Lounge because the activity was over. Note: This was 13 minutes after the 'News' activity was scheduled to start. *10/8/14 at 10:31 AM-8 out of 8 who attended the 'News' activity began to leave the Chapel because the activity was over. Note: This was 1 minute after the 'News' activity was scheduled to start.</p> <p>On 10/8/14 at 1:55 PM, the Activity Director (AD) was interviewed regarding the activity issues. When asked if there was variety in the morning activities, she stated, "No." She said the residents who attended Exercise, Devotions, and News, like the regular routine of having them every day in the morning. She said they tried to change it in the past, but residents complained. When asked what the other residents who did not attend those activities did during this time, she said another staff member either visited residents or worked on sensory stimulation for residents with cognitive impairments 4 days a week. When asked why</p>	F 248		

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F 248	<p>Continued From page 8</p> <p>this was not part of the calendar, she said due to staff shortages she could not rely on it being a calendar item and also the AD felt it was degrading to residents to put "sensory stimulation" on the calendar. When asked why there were so many residents in the Activity Area without anything to do when the three activities were going on, she said there was only so many staff who could assist residents to the activities. When informed about the 'News' activities length, she said most residents who attend that activity were there for the previous two activities. She said staff usually fit all 3 activities in just over an hour, so residents could go to the bathroom. When asked why they did not have a break in between activities and allow new residents to join the 'News' activity, she stated, "It's kind of hard right now," due to staffing shortages. Note: Refer to F353 regarding lack of staff.</p> <p>2. Resident #7 was admitted to the facility on 3/13/13 with multiple diagnoses including cerebral artery occlusion and osteoporosis.</p> <p>The resident's quarterly MDS assessment, dated 9/16/14, documented the resident was moderately cognitively impaired with a BIMS of 11 and was moderately depressed.</p> <p>The resident's Activity Interest Data Collection Tool, dated 6/26/14 by the AD, documented, "[Resident Name] prefers to observe activity is quiet but friendly-enjoys brief visits. Her husband [r]ecently passed whom she would sit with during the day..."</p> <p>The resident's care plan documented: 5/29/14-Focus of, "The resident has little or no activity involvement R/T [related to] preference to</p>	F 248			

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F 248	<p>Continued From page 9</p> <p>observe and overall disinterest in group activities E/B [exhibited by] sitting in lounge and declining invitations to activity programs." 9/23/14-Intervention of, "Resident's preferred activities are: sitting in lounge and observing general activities, visiting with family, residents. Looking through magazines and intergenerational opportunities and western music (Old Time Fiddlers)."</p> <p>During the survey, the following observations were conducted: *10/6/14 9:32 AM-The Resident was in the Activity Area asleep in her wheelchair; 10:11 AM-The Resident was in the Activity Area and awake; 11:15 AM-The Resident self-ambulated her wheelchair into the Activity Area and stopped opposite where she was on the previous observations; 1:15 PM-The Resident was in the hallway in her wheelchair outside of her room; 2:30 PM-The Resident was asleep in her bed; 4:05 PM-The Resident was in the Activity Area visiting with a visitor; *10/7/14 10:15 AM-The Resident was in her room in her wheelchair; and, 10:41 AM-The Resident was in the Activity Area in her wheelchair.</p> <p>On 10/7/14 at 10:15 AM, Resident #7 was interviewed. When asked about activities she stated, "I'm bored a lot... There's not much to do." When asked what she did all day, she stated, "Not much of anything." When asked what activities she would like to participate in, she said the news. When asked if staff offered her to</p>	F 248			

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F 248	Continued From page 10 participate in an activity lately, she stated, "No." When asked if staff were to offer her an activity, would she participate in it, she stated, "Sure I would." On 10/8/14 at 10:30 AM, the Resident was asked if staff had asked her to attend the 'News' activity scheduled for that time and she said they had not. When asked if she would attend if she was invited, she said, "Yes."  On 10/8/14 at 1:45 PM, the AD was interviewed regarding the resident's activities. When asked about the resident's care plan and assessments, she said the resident did not participate very often in group activities. When asked if staff offered the resident activities, she stated, "Because of our staffing, we don't get around to asking those who don't come out for activities." When informed of the surveyors interview with the resident who expressed interest in the news, the AD stated, "We will invite her." The AD said when the resident's her husband was alive, they would both sit in the Activity Area together and family would come visit them often. When asked if family still visited often, the AD said family visits had decreased since the death of the resident's husband and maybe she was bored now. The AD also said she would visit with the resident regarding her expressed interests and update the resident's care plan.	F 248			
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged	F 280			

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F 280	<p>Continued From page 11</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 observation, staff and resident interview and record review, it was determined the facility failed to ensure resident care plans were reviewed and revised to reflect their current needs and status. This was true for 4 of 12 residents (#s 3, 5, 6, 7, and 8) reviewed for care plan revisions. The deficient practice had the potential to cause harm if care were provided or treatment decisions made based on outdated or inaccurate information. Findings included:</p> <p>1. Resident #6's most recent annual MDS dated 7/7/14 documented she was frequently incontinent of urine. However, the resident's care plan did not include interventions, goals, or approaches for toileting.</p>	F 280	<p>F tag 280 SS=E</p> <p>1. a) NA – Resident #3 expired. b) Resident #5 re-assessed for ambulation status. Care plan was updated to reflect current needs and status. c) Resident # 6 was re-assessed on November 3, 2014, for 72 hour bowel/bladder activity and assistance needed. Care plan was updated to reflect identified needs and interventions, goals and approaches to toileting assistance. Resident was re-assessed to identify triggers for striking out behavior to enable staff to anticipate and prevent this behavior and care plan was updated to include targeted interventions. d) Resident # 7 – Need for bedside commode was re-evaluated and care plan updated to reflect current needs and status. e) NA - Resident # 8 – except in the Requirement section, Resident #8 was not identified anywhere else in this tag.</p> <p>2. All residents have potential to be affected by this practice. 3. Care plan team has been re-educated regarding how to identify residents' current needs and status. Consistent assignment staff will be actively involved in the care plan development and review process and educated on this change. 4. DNS or designee will audit care plans weekly x 4, bi-weekly x 4 and monthly x 2. All audit findings will be reported to QAPI committee monthly for further monitoring and modification.</p>	<p>December 4, 2014</p> <p>12.8.14 Per Admin. 12.4.14 D.S.</p>	

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F 280	<p>Continued From page 12</p> <p>Resident #6 had a resident to resident altercation in the facility's living room on 8/25/14. No specific care plan approaches were added so the staff knew when to anticipate such a behavior and how the behavior could be prevented. The resident struck another resident in a similar circumstance on 9/22/14.</p> <p>2. Resident #5 was admitted to the facility on 3/12/13 with multiple diagnoses including paralysis agitans and dementia.</p> <p>The resident's quarterly MDS assessment dated 7/2/14, documented the resident had not walked in the corridor.</p> <p>The resident's ADL care plan documented on 10/8/13, an intervention of, "Walk to [Resident #5]'s room 50-60 feet..."</p> <p>On 10/8/14 at 11:05 AM, the DON was interviewed regarding the care plan. She stated the resident no longer walked due to her decline in health and the intervention on the care plan should have been removed.</p> <p>3. Resident #7 was admitted to the facility on 3/13/13 with multiple diagnoses including cerebral artery occlusion, osteoporosis, and dementia.</p> <p>The resident's quarterly MDS assessment dated 9/16/14, documented the resident was continent of bowel and bladder.</p> <p>The resident's care plan had an intervention on 10/7/13 of, "Toileting assist of one. Has bed side commode next to bed."</p>	F 280			

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F 280	<p>Continued From page 13</p> <p>On 10/6/14 at 9:30 AM, and subsequent observations throughout the survey, the resident's room was observed and no commode was found in the room.</p> <p>On 10/8/14 at 3:40 PM, the DON was interviewed regarding the commode. When asked if the resident had a commode in the room, she stated, "No, she does not." She said it should have been taken off the care plan.</p> <p>4. Resident #3 was readmitted to the facility on 2/27/14 with multiple diagnoses which included legal blindness.</p> <p>The most recent quarterly MDS assessment, dated 9/4/14, documented Resident #3 required extensive assistance with 1 person for eating.</p> <p>Resident #3's ADL Care Plan, dated 1/13/14, documented, "Resident is able to feed self after set up."</p> <p>The Nutritional Care Plan for Resident #3, dated 1/17/14, documented, "Provide set up at meals, cue and extensive assist when needed..."</p> <p>On 10/7/14 at 10:10 a.m., the DON was asked what the Care Plan documented about the assistance Resident #3 needed for eating. After the DON reviewed the Care Plan she responded, "Says cue and provide extensive assist when needed," and, "It says able to feed self after set up." The DON acknowledged the contradictory information and stated, "I can change that today."</p> <p>On 10/8/14 at 4:30 p.m., the Administrator and DON were informed of the care plan revision concerns. No further information or</p>	F 280			

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F 280	Continued From page 14 documentation was provided.	F 280	F tag 309		
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 observation, resident and staff interview, review of facility incident reports and record review, it was determined the facility did not ensure residents received care consistent with their needs for dementia or skin conditions, or that care was provided per resident care plans. This was true for 2 of 12 (#s 5 and 6). This deficient practice created the potential for residents to not receive the care they needed for their specific conditions. Findings included:  1. Resident #6 was admitted to the facility in 2012 following a hip fracture.  On 2/14/14, the resident's physician documented the resident, "is awake, but good memory."  On 4/7/14, Resident #6's quarterly MDS assessment coded a BIMS score of 13, indicating mild cognitive impairment.  On 4/18/14, the physician documented, "Awake, alert. Memory is very diminished, both long term	F 309	SS=D 1. a) Resident #5: Resident sleep, preferences, and patterns were reassessed and the care plan was updated. b) Resident #6: Care plan was updated with triggers for striking out and diversionary activities. 2. All residents with impaired cognition, identified by BIMS score, have the potential to be affected and will be audited for care plan accuracy. All residents with dementia and skin conditions, as identified by a Braden of 14 or less and a diagnosis of dementia, have the potential to be affected by this practice and will be audited for napping preferences. 3. The QAPI process identified the root cause of deficiency as not updating care plans, not reporting care plan changes in shift to shift report, and not providing cares in accordance with care plan interventions. The system change is that shift to shift report will be changed to now include CNAs (with the nurses) and to provide care plan changes at report. Nurses will be educated on this process change. 4. DNS or designee will monitor shift to shift reporting for care plan updates daily x 5, weekly x12, and monthly x2. All audit findings will be reported to QAPI committee monthly for further monitoring and modification.	December 8, 2014	

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F 309	<p>Continued From page 15 and short term..."</p> <p>On 4/29/14, Resident #6's care plan was updated with a focus area of, "[Resident #6] has impaired cognitive function and impaired thought processes [related to] dementia [as evidenced by] memory deficit." The documented goal was that the resident would be able to find her own room, find the bathroom, and recognize family members. The only intervention documented on that date was, "Present just one thought, idea, question, or command at a time. When confused explain and remind." There was no documentation regarding her past preferences and interests. There was no documentation directing the staff that the resident had experienced a change in her cognitive function, and may require additional cues or assistance to successfully navigate her day.</p> <p>On 7/7/14, Resident #6's Annual MDS assessment coded: *BIMS of 14, indicating the resident was cognitively intact; *It was very important for the resident to have reading materials and music of her choice; and *It was somewhat important for the resident to participate in religious services.</p> <p>On 8/26/14 at 8:25 AM, a facility incident report documented Resident #6 was sitting in the facility's living room next to a resident known to call out loudly. When the resident began to call out, Resident #6 struck the resident.</p> <p>On 8/26/14, the intervention of, "Resident needs reminding that it is not OK to hit other residents when she is upset with them. Contact staff for assistance," was added to Resident #6's</p>	F 309		

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F 309	<p>Continued From page 16</p> <p>cognitive loss care plan. There were no interventions added as what might cause Resident #6 to become upset with other residents, how to anticipate and avoid such situations, whether it might be necessary to offer Resident #6 something to do rather than sit in the facility's living room, or what kind of leisure pursuits may be interesting to her.</p> <p>On 9/22/14 at 6:40 PM, a facility incident report documented Resident #6 was sitting in the facility's living room next to a different resident known to make spontaneous noises. When the resident began to make noises, Resident #6 struck her.</p> <p>On 9/23/14, a focus area of, "The resident has a behavior symptom...may strike out at others when they startle her or make noises next to her," was added to Resident #6's care plan. The documented goal was, "Resident will have no evidence of striking out at others..." The interventions included to intervene as necessary to protect the rights and safety of others by diverting the resident's attention and removing her from the situation, and to assist the resident to develop more appropriate methods of coping and interacting such as telling staff when others are bothering her and not slapping them.</p> <p>On 10/6/14 at 10:00 AM, Resident #6 was observed in her bed in her room. The lights were not on and the room was dark. The resident was awake. The resident stated it was her choice to be in bed at that time, but readily engaged in conversation about the decorations in her room. When asked if the surveyor could come back later to continue the conversation, the resident stated, "Come back any time. I'll be here all day. I</p>	F 309		

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F 309	<p>Continued From page 17</p> <p>have no plans whatsoever." The resident remained in the room until 11:00 AM.</p> <p>On 10/6/14 at 3:30 PM, the resident was again in her bed in a dark room. A folded newspaper was laying on her torso. The resident stated she had not had a chance to read the newspaper yet, as she had been busy with "sacrament class." When asked if the class was something she attended in the facility, the resident stated, "Come to think of it, no. I just lay here in my room and think about it. Did you know James was Jesus' brother? I find that interesting. I wonder how many other people realize that?"</p> <p>On 10/7/14 at 11:30 AM, and at 5:45 PM, Resident #6 was observed in the dining room for the lunch and dinner meal. The resident was laughing and joking with her tablemates and their visitors. She stated, "I sure like the people here. They're good people."</p> <p>On 10/8/14 at 8:30 AM, LSW #8 was asked if the facility had considered boredom or fatigue as a possible factor in Resident #6's resident to resident altercations. The LSW stated she didn't think so, because the facility had lots of videos on history and farming that the resident could access independently if she wanted to, and that the resident liked dogs. The LSW was unable to describe how the facility had developed an individualized, person-centered care plan for Resident #6 after the physician and the facility had identified her cognitive loss.</p> <p>On 10/8/14 at 4:30 PM, the Administrator, DNS, and LSW #8 were informed of these findings. The facility offered no further information.</p>	F 309			

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F 309	<p>Continued From page 18</p> <p>2. Resident #5 was admitted to the facility on 3/12/13 with multiple diagnoses including paralysis agitans and dementia.</p> <p>The resident's quarterly MDS assessment dated 4/4/14, documented the resident required one person extensive assistance with transfers.</p> <p>The resident's quarterly MDS assessment dated 7/2/14, documented the resident was severely cognitively impaired with a BIMS of 7.</p> <p>The resident's care plan had a revised intervention dated 4/10/14 of, "Give resident adequate rest periods. Resident prefers, to rest for nap in afternoon [sic] and may nap in mornings sometimes as well."</p> <p>The following resident observations were made: -10/6/14 at 11:20 AM, the resident was at a table in the SCU (Special Care Unit) dining room, slouched in her wheelchair asleep; -1:20 PM, the resident was in the same spot as before, asleep in her wheelchair and her eyeglasses had slid down her face and no longer rested on her nose; -4:00 PM, the resident was at a table in SCU with a finished craft in front of her. She was slouched in her wheelchair asleep; -10/7/14 at 1:22 PM, the resident was at a table in the SCU in her wheelchair asleep. Her head was slumped over and her eyeglasses were askew and had slid down her face and no longer rested on her nose; and, -2:05 PM, the resident was in the SCU lounge area asleep in her wheelchair. Her head was slumped onto her chest with her legs and feet covered with a bed sheet.</p>	F 309			

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F 309	Continued From page 19 On 10/8/14 at 2:10 PM, LN #1 was interviewed regarding the resident's sleeping observations. LN #1 said the resident refused to lay down on 10/7/14 when offered. When asked if the resident was offered to lay down on 10/6/14, she said staff had not offered.  On 10/8/14 at 11:05 AM, the DON and RN Case Manager #5 were interviewed. When asked about the care plan and informed about the observations, RN Case Manager #5 said the resident often refused to be laid down. The surveyor then asked for documentation regarding the refusals. On 10/8/14 at 3:40 PM, RN Case Manager #5 informed the surveyor the documentation could not be found.	F 309	<p style="text-align: center; font-size: 2em; opacity: 0.5;">RECEIVED</p> <p style="text-align: center; font-size: 1.5em; opacity: 0.5;">DEC 04 2014</p> <p style="text-align: center; font-size: 1.5em; opacity: 0.5;">FACILITY STANDARD</p> <p>F tag 312 SS=D 1. Resident #1 - N/A - discharged November 3, 2014. Resident # 2 - Bathing schedule was reviewed and Audit was done October 8, 2014. Care plan updated to reflect resident preferences. Resident # 3 - expired. 2. All residents <del>with an ADL self care deficit</del> have the potential to be affected by this practice and will be audited to ensure baths are given/documented. 3. QAPI process identified the root causes of the deficiency as staff not following the bath schedule, not charting all baths given and not offering a bath after refusals. The system change is that CNAs are to provide a custom alert when baths are refused or not given, the LN is to write an IDP note that indicates the reason for a missed bath, and the DNS or designee will interview resident with a pattern of refusals of 1 week, document, and make changes as needed. All nursing staff will be educated on the process to ensure bathing occurs. 4. DNS or designee to audit all baths given daily x 5 days, weekly x3, and monthly x 2. All audit findings will be reported to QAPI committee monthly for further monitoring and modification.</p>		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to adequately ensure residents received baths/showers as needed and scheduled. This was true for 3 of 12 (#s 1-3) sampled residents. This deficient practice had the potential to cause more than minimal psychological and/or physical harm if residents experienced rashes, skin issues, infections and loss of esteem and depression. Findings included:	F 312			<p style="font-size: 1.5em; text-align: right;">12/11/14 2:30PM AB PER ADMIN STRIKE OUT</p> <p style="text-align: right; font-size: 0.8em;">December 8, 2014</p>

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F 312	<p>Continued From page 20</p> <p>1. Resident #1 was readmitted to the facility on 7/30/14 with multiple diagnoses which included cerebrovascular disease and pruritic disorder.</p> <p>The most recent admission MDS assessment for Resident #1, dated 8/6/14, documented:            * Cognitively impaired with a BIMS of 4;            * Required extensive assistance of 2 people for bed mobility, transfers, dressing, personal hygiene, toilet use and bathing; and,            * Frequently incontinent of bowel.</p> <p>Resident #1's Care Plan documented the focus, "The resident has an ADL self care performance deficit R/T CVA E/B [related to cerebrovascular accident evidenced by] left sided weakness," with a date of 7/30/14, and an intervention included, "BATHING: Resident is totally dependent on staff to provide a bath," with a date of 8/14/14.</p> <p>The August and September 2014 Documentation Survey Report (Type: bathing) documented Resident #1 received one whirlpool bath, on 8/30/14, for the month of August; received a tub bath on 9/17 and a whirlpool bath on 9/24 for the month of September.</p> <p>On 10/8/14 at 3:35 p.m., the DON was asked how many times Resident #1 was bathed/showered in August 2014 and she stated, "It doesn't look like she got them but once." The DON said she would ask Occupational Therapy about the bathing/showers in September 2014.</p> <p>Resident #1 received a total of 3 baths/showers for the months of August and September 2014.</p> <p>2. Resident #3 was readmitted to the facility on</p>	F 312			

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F 312	<p>Continued From page 21 2/27/14 with multiple diagnoses which included senile dementia and legal blindness.</p> <p>The most recent quarterly MDS assessment for Resident #3, dated 9/4/14, documented: * Severe cognitive impairment; * Total assistance for bathing; * Always incontinent of bowel and frequently incontinent of bladder; and, * Had a Stage II pressure ulcer.</p> <p>Resident #3's Care Plan documented the focus, "The resident has an ADL self care performance deficit R/T weakness, altered mental status[,] Depression and CHF [congestive heart failure]," and an intervention included, "BATHING: Resident requires 1 staff participation with bathing," with a date of 1/13/14.</p> <p>The August 2014 Documentation Survey Report (Type: bathing) documented Resident #3 received a bed bath on 8/1 and 8/5, received a tub bath on 8/8, bath/shower did not occur on 8/12, not applicable on 8/15, resident refused on 8/19, received a whirlpool bath on 8/22, not applicable on 8/28 and received a bed bath on 8/29.</p> <p>The September 2014 Documentation Survey Report (Type: bathing) for Resident #3 documented a bath/shower was not applicable on 9/2, received a bed bath on 9/5, resident refused on 9/9, not applicable on 9/12, received a tub bath on 9/16, resident refused on 9/19 and 9/23, and received a bed bath on 9/26 and twice on 9/30.</p> <p>On 10/8/14 at 3:45 p.m., the DON was asked how many baths/showers Resident #3 received for</p>	F 312		

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F 312	<p>Continued From page 22</p> <p>August 2014 and she stated, "5." The DON said the resident received, "4" baths/showers in September 2014.</p> <p>Resident #3 received only 5 baths/showers in August 2014 and there was no follow-up when the resident refused. The resident received only 5 baths/showers in September 2014 with no follow-up when the resident refused.</p> <p>On 10/8/14 at 4:30 p.m., the Administrator and DON were informed of the bathing concerns. No further information or documentation was provided.</p> <p>3. Resident #2 was admitted to the facility on 9/4/12 with multiple diagnoses including pressure ulcer to the buttock, impetigo, and renal failure.</p> <p>The resident's quarterly MDS assessment dated 8/22/14, documented the resident required two person extensive assistance with transfers and one person extensive assistance with bathing.</p> <p>The resident's ADL care plan documented an intervention on 12/2/13 of, "Bathing: Resident requires 1 staff participation with bathing,"</p> <p>Record review revealed the resident only received 5 showers in August and 6 showers in September 2014.</p> <p>On 10/8/14 at 11:00 AM, the DON was interviewed. When asked what the expectation was to bathe residents, she stated residents, "should be having them twice a week." When The DON was shown the resident's bathing report, she stated, "So he's missing showers, yeah."</p>	F 312			

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F 314 F 314 SS=G	Continued From page 23 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, Policy and Procedure review and record review, it was determined the facility failed to: * Prevent pressure ulcers from developing; * Prevent healed pressure ulcers from recurring; * Ensure a resident's skin care plan interventions were effective; * Ensure interventions were updated after residents developed pressure ulcers; * Ensure skin and pressure ulcer assessments were completed and accurate; * Ensure treatment orders were received and implemented; and, * Ensure the physician was notified of changes in condition related to pressure ulcer size. This affected 3 of 5 residents (#s 1, 3 and 12) reviewed for pressure ulcers. The deficient practice caused harm to Resident #1 when the resident developed 2 Stage II pressure ulcers to the left and right buttock while in the facility, caused harm to Resident #3 when a healed Stage II pressure ulcer reopened as a Stage II	F 314 F 314	F tag 314 SS=G 1. Residents #1 - NA - discharged November 3, 2014. Resident #3 - NA - expired. (Resident #3 healed on November 4, 2014.) Resident #12 was reassessed and care plan was updated. 2. All residents with a Braden score of 14 or less, residents admitted with at risk diagnosis, actual open area/pressure ulcer, and any resident who is found to have skin breakdown by CNA or LN have the potential to be affected by this practice. Braden audits will be completed on all residents. 3. The QAPI process identified the root cause as the lack of nurse education and lack of a 2 person verification process when identifying wounds to ensure accuracy. The system change is that weekly skin rounds by DNS and Care Managers ("wound team") were initiated. The Wound team will ensure accuracy of assessment/documentation, notification of MD, implementation of treatment, and ongoing reassessment and prevention. All licensed nurses and CNAs will be re-educated on the practice of Pressure Ulcer prevention and management. Care managers attended the PUPC wound care seminar on November 7, 2014 4. Weekly wound rounds will be completed by DNS and/or Care managers. DNS or designee will audit skin accuracy of assessment/documentation, notification of MD, implementation of treatment, and ongoing reassessment and prevention weekly x4, monthly x2, quarterly x3. All audit findings will be reported to QAPI committee monthly for further monitoring and modification.	December 8, 2014

RECEIVED

DEC 04 2014  
ADMINISTRATOR WILL AUDIT THE PROCESS TO ENSURE IT IS COMPLETED.

WEEKLY X4, MONTHLY X2, QUARTERLY X3.

12/11/14 @ 2:35 PM

PER ADMIN

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F 314	<p>Continued From page 24</p> <p>pressure ulcer on the left buttock, and created the potential for more than minimal harm when Resident #12's pressure ulcer was not assessed correctly. Findings included:</p> <p>The facility's Pressure Ulcer Practice Guidelines, revised on 6/14, documented:</p> <ul style="list-style-type: none"> <li>* Develop and implement individualized prevention strategies and include on the Care Plan;</li> <li>* Report changes to the resident's primary care provider and document notification;</li> <li>* Perform weekly skin checks;</li> <li>* Perform at a minimum weekly documentation of pressure ulcer/wound characteristics; and,</li> <li>* Reevaluate the treatment plan and interventions.</li> </ul> <p>1. Resident #1 was readmitted to the facility on 7/30/14 with multiple diagnoses which included cerebrovascular disease.</p> <p>The most recent admission MDS assessment for Resident #1, dated 8/6/14, documented:</p> <ul style="list-style-type: none"> <li>* Impaired cognition with a BIMS of 4;</li> <li>* Required extensive assistance for bed mobility, transfers, dressing, personal hygiene, bathing and toilet use;</li> <li>* Range of motion impairment for the upper and lower extremities on one side;</li> <li>* Frequently incontinent of bowel; and,</li> <li>* Had a Stage 1 pressure ulcer or greater with new skin growing in the superficial ulcer.</li> </ul> <p>Resident #1's Care Plan, with a date of 8/25/14, documented a focus, "The resident has potential for pressure ulcer development R/T [related to] immobility and incontinence," and interventions which included, "Educate resident/family as to</p>	F 314		

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F 314	<p>Continued From page 25</p> <p>causes of skin breakdown including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning; Encourage, assist, supervise with use of assist bar for resident to assist with turning; Provide pressure relieving mattress on bed and cushion in chair."</p> <p>A Nursing Admit Re-admit Data Collection Progress Note for Resident #1, dated 7/30/14, documented the resident was admitted with a, "small stage one pressure ulcer 5*2cm [5 x 2]" on the left buttock. A Wound RN Assessment, dated 8/8/14, documented the Stage 1 pressure ulcer healed.</p> <p>The Braden Scale, dated 7/30/14, documented a score of 16 which placed Resident #1 at mild risk of developing pressure ulcers.</p> <p>The following documentation was gathered from Resident #1's Wound Data Collection (WDC), Wound RN Assessment (WRA) and Progress Notes (PN):</p> <p>* 8/14/14 (WDC) - Wound name: "pressure wound on upper left buttock at level of coccyx wound bed pale pink;" Type: Left buttock; Initial data collection on wound which was not present on admission/readmission; Measurements: 1.2 x 0.8 cm; Presence of possible complications: "whole of area is dark pink but blanchable. Has shearing going on;" 100% epithelialized; Surrounding Skin: intact, pink skin without any open areas or drainage; Dressing and/or Treatment: "will ask MD for calmoseptine as area is hard to keep clean;"</p> <p>* 8/14/14 (WRA) - Type: Left buttock; Wound name: "pressure area left upper buttock at level of coccyx has pale pink wound bed;" Type of</p>	F 314		

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F 314	<p>Continued From page 26</p> <p>wound: Pressure ulcer; Staging; Stage 2; Healing process: "new wound;" Modifications to Interventions: Repositioning/turning, support surfaces, moisture/incontinence protection and wound treatment; Physician Notification and Documentation: Physician was notified regarding wound status;</p> <p>* 8/14/14 (WRA) - Left buttock; "most distal stage 2 pressure area on left buttock;" Pressure ulcer; Stage 2; "new;" Repositioning/turning, support surfaces and wound treatment; Physician was notified regarding wound status;</p> <p>* 8/14/14 (WDC) - "pressure area on right buttock;" Initial data collection on wound which was not present on admission/readmission; 0.5 x 0.5 cm; "tissues on bottom are a blanchable deep pink;" 100% epithelialized; "will ask MD for calmoseptine;"</p> <p>* 8/14/14 (WRA) - Right buttock; "stage 2 pressure area right buttock with pink center;" Stage 2; "new;" Repositioning/turning, support surfaces and wound treatment; Physician was notified regarding wound status;"</p> <p>* 8/14/14 (PN Nutritional Status) "...Has 3 stage 2 wounds on her bottom. Will add air overlay and roho cushion to care plan...;" and,</p> <p>* 8/14/14 (PN Communication/Visit with Physician) "[Resident's name] has 3 new stage 2 pressure areas on bottom the largest of which is 1.2 x 0.8 [cm]. May we try calmoseptine cream to wounds to see if they will heal?"</p> <p>The August 2014 TAR for Resident #1 contained open boxes on the assigned days for LNs to document the skin assessment. On 8/13/14 the boxes were left blank.</p> <p>Resident #1's September and October 2014 MRR (recapitulated Physician's Orders) included,</p>	F 314			

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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>	
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F 314	<p>Continued From page 27</p> <p>"SKIN ASSESSMENT...Q [Every] WEEK...every day shift every Sat[urday]." The September 2014 MRR documented a discontinued order for the assessment to be completed on Wednesdays.</p> <p>On 10/6/14 at 9:30 a.m., Resident #1 was interviewed while she rested in bed on an air mattress. The resident said the mattress was for wound prevention but currently she did not have any wounds.</p> <p>On 10/7/14 at 3:55 p.m., the DON was interviewed regarding Resident #1's skin. The DON said the identified risk factors for pressure ulcer development were immobility, potential for altered nutrition and bladder incontinence. The DON identified interventions put into place on admit as skin care right away for the existing Stage 1 pressure ulcer, a pressure relieving mattress which all beds in the facility had, and a cushion in the wheelchair. When asked what interventions were put into place after the development of multiple pressure ulcers, the DON said the Physician was called and faxed for calmoseptine cream. The DON added there would be an order for the cream if the physician agreed with the suggestion. After reviewing discontinued medications for Resident #1, the DON stated she did not find the order but would continue to look. Documentation of the Physician's order for the cream was requested but not provided.</p> <p>Resident #1 was admitted to the facility with a Stage 1 pressure ulcer which healed. The skin check on 8/13/14 was not completed as ordered, and the resident acquired 3 new Stage II pressure ulcers, 2 on the left buttock and 1 on the right buttock on 8/14/14. The Care Plan did not</p>	F 314		

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F 314	<p>Continued From page 28</p> <p>reflect skin breakdown had occurred, did not direct staff to reposition the resident, nor did it direct staff how often repositioning should occur. Modifications to the skin care plan were not made after the development of multiple pressure ulcers and treatment orders were not received by the physician. In addition, the only assessments and skin documentation provided for the 3 Stage II pressure ulcers were on 8/14/14.</p> <p>2. Resident #3 was readmitted to the facility on 2/27/14 with multiple diagnoses which included senile dementia with delusional features and diabetes.</p> <p>The most recent quarterly MDS assessment for Resident #3, dated 9/4/14, documented:          * Severely impaired cognition - resident unable to complete interview;          * Required extensive assistance for bed mobility, dressing personal hygiene and toilet use;          * Required total assistance for transfers and bathing;          * Range of motion impairment on bilateral lower extremities;          * Always incontinent of bowel and frequently incontinent of bladder; and,          * One unhealed Stage II pressure ulcer not present on prior assessment.</p> <p>A Nursing Admit Re-admit Data Collection Progress Note for Resident #3, dated 2/27/14, documented the resident was admitted with, "has 2 areas- 1) Left side of coccyx= 2cm x 1.5 cm and superficial, 2) right side of coccyx [sic] = 3cm x 1.5 cm and superficial."          A Wound RN Assessment, dated 3/19/14, documented, "initially admitted with two pressure ulcers to coccyx 2*1.5 [cm] and 3*1.5 [cm]. now</p>	F 314			

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F 314	<p>Continued From page 29</p> <p>one pressure ulcer measuring 1.5*1.5 [cm]." The assessment identified the wound as a Stage II pressure ulcer.</p> <p>An additional Wound RN Assessment, dated 5/12/14, documented the remaining pressure ulcer had healed and to discontinue the weekly RN assessments.</p> <p>Resident #3's Care Plan, with an initiation date of 6/10/14, documented the focus, "The resident has stage 2 pressure ulcer to coccyx R/T immobility," and interventions included, "Provide low-air loss mattress on bed and cushion in chair; TRANSFER resident to bed to rest after meals."</p> <p>The following documentation was gathered from Resident #3's Wound Data Collection (WDC), Wound RN Assessment (WRA), Progress Notes (PN) and Care Plan (CP):</p> <p>* 7/3/14 (PN MD/Nursing Communications) - "Resident has a small stage two pressure ulcer developing on her coccyx. At this time the wound is 1 X 0.5 cm. May we resume her orders for silvasorb ointment and cover with a copa dressing QD [every day] to treat?" The MD responded with, "yes;"</p> <p>* 7/10/14 (WRA) - Type: Coccyx; Type of wound: Pressure ulcer; Staging: Not documented; Healing Process: "Regranulation tissue surrounding the wound. Wound itself is pale pink, no swelling, no foul drainage, no skin redness;"</p> <p>Modifications to Interventions: Repositioning/turning and wound treatment; Physician Notification and Documentation: Continue with current plan of treatment;</p> <p>* 7/11/14 (WDC) - Type: Coccyx; Not initial data collection on wound; (Note: First WDC after admit pressure ulcer healed and area reopened)</p> <p>Measurements: 0.3 x 0.3 cm; Dressing present,</p>	F 314			

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F 314	Continued From page 30 intact, no drainage or leaking; Wound Characteristics: 75% epithelialized and 25% granulation; Dressing and/or Treatment: "silvasorb covering with copa;" * 7/12/14 (WDC) - Coccyx; 1.5 x 1 cm, "Moist whitish wound bed with surrounding tissue pink;" 10% epithelialized and 90% granulation, minimum amount of serous drainage; "silvasorb and absorbent dressing;" * 7/13/14 (WDC) - Coccyx; 1.5 x 1.5 cm; "Wound is moist-wound bed whitish with surrounding tissue pink and blanchable. No s/s [signs and symptoms] of infection;" (Similar Wound Data Collection documentation without measurements or wound characteristics 7/14/14 - 7/18/14, 7/23/14, 7/25/14, 8/5/14 - 8/9/14, 8/12/14 - 8/15/14, 8/17/14 - 8/19/14, 8/21/14 - 8/22/14, 8/24/14 - 9/13/14, 9/17/14 - 9/22/14) * 7/19/14 (WDC) - Coccyx; 1 x 1 cm, "wound is whitish and moist with surrounding tissue pink and blanching with < [less] than 2 sec. [second] capillary refill;" 80% granulation and 10% slough, minimum serous drainage; "hydrophilic dressing with Silvasorb applied;" * 7/24/14 (WRA) - Coccyx; Stage 2, "new skin growth, no s/s of infection at this time;" No modifications to interventions; Continue with current plan of treatment; * 7/26/14 (WDC) - Coccyx; 2 x 3 cm 10% epithelialized and 80% granulation; * 7/31/14 (WRA) - Coccyx; Healing Stage 2, "new growth;" No modifications to interventions; * 8/4/14 (WDC) - Coccyx; 0.5 x 0.5 cm; * 8/7/14 (WRA) - Coccyx; Healing Stage 2, "new growth around area;" No modifications to interventions; (Similar Wound RN Assessment documentation on 8/21, 9/4 and 9/11/14)	F 314			

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F 314	<p>Continued From page 31</p> <ul style="list-style-type: none"> <li>* 8/11/14 (WDC) - Ccccyx; 1 x 1 cm with dressing intact;</li> <li>* 8/16/14 (WDC) - Ccccyx; 2 x 1.5 cm;</li> <li>* 8/20/14 (WDC) - Ccccyx; 1 x 1 cm with dressing present and intact with drainage;</li> <li>* 8/23/14 (WDC) - Ccccyx; 2.5 x 1 cm;</li> <li>* 8/28/14 (WRA) - Ccccyx; Repositioning/turning and pain management;</li> <li>* 9/16/14 (WDC) - Ccccyx; 2.5 x 3 cm, "wound is larger at this time, appears to have more superficial damage to surrounding area;"</li> <li>* 9/23/14 (WRA) - Ccccyx; Stage 2; "Wound has incresed [sic] in size;" Repositioning/turning, support surfaces, nutritional, moisture/incontinence protection, friction/shear management and wound treatment; Physician was notified regarding wound status; "Wound has not been healing and in the last week has increased in size. MD notified of wound change and requested to see resident in clinic;"</li> <li>* 9/26/14 (CP) - Interventions added: "Assist resident to turn/reposition at least every 2 hours. Reposition with 1 person assist; Avoid positioning resident on back; Provide low-air loss mattress on bed and cushion in chair;" and,</li> <li>* 9/30/14 (WRA) - Ccccyx; Stage 2; "Wound increased in size;" (Note: No correlating measurements on WRA or WDC)</li> </ul> <p>Repositioning/turning, support surfaces, nutritional, moisture/incontinence protection, wound treatment and pain management; Physician was notified regarding wound status; "Resident was seen by MD on 9/29/14 who reported that we currently have all the interventions in place that he can think of and referred her to [MD's name]. Referral sent to [local wound clinic]."</p> <p>August through October 2014 MRRs</p>	F 314			

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F 314	<p>Continued From page 32</p> <p>(recapitulated Physician's orders) for Resident #3 included, "high sided Panacea mattress [sic]," ordered on 3/31/14, "Weekly skin assessment with VS every evening shift every Fri[day]," ordered on 3/5/14 and, "SilvaSorb Gel (Wound Dressings) Apply to pressure ulcer topically every evening shift related to PRESSURE ULCER, STAGE II...Apply and cover with copa dresing [sic] once daily," ordered on 7/9/14.</p> <p>The July through October 2014 TAR for Resident #3 documented the aforementioned Physician's orders. The dressing change was not performed on 7/27/14, 8/17/14 and 9/21/14.</p> <p>On 10/6/14 at 9:43 a.m. until 11:10 a.m., Resident #3 was observed sitting in her wheelchair in the lounge area near the nurse's station. At 11:37 a.m., the resident was observed sitting in her wheelchair in the dining room, and at 1:10 p.m., the resident was observed sitting in her wheelchair in the lounge area.</p> <p>On 10/8/14 at 10:20 a.m., the DON was interviewed. She said Resident #3 had a Stage III or Stage II, "That is just not healing," and said the resident was taken to see the physician for input, and the physician referred the resident to a wound clinic in a nearby city. The DON said the resident had been on comfort care and the facility had looked into the nutritional component, but the family did not want any nutritional support. The DON was asked how staff knew to reposition the resident every 2 hours and where it would be documented. She stated, "That's a standard of care, wouldn't necessarily put that on the care plan," and, "I don't know they'd document that." When asked how measurements were obtained when the dressing was in place, the DON stated,</p>	F 314			

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F 314	<p>Continued From page 33</p> <p>"Good question, possibly pulling last measurements forward."</p> <p>On 10/8/14 at 11:05 a.m., LN #6 was interviewed regarding Resident #3. The LN said the pressure ulcer was a Stage II on admit, healed and reopened as a Stage II. The initial interventions for pressure ulcer prevention included a pressure relieving mattress, repositioning every 2 hours at least, extra protein with meals and a pressure relieving cushion in the wheelchair. LN #6 said the interventions changed after pressure ulcer development to a low air loss mattress and a roho cushion to the wheelchair. The LN added the physician could not think of anything else to try and referred the resident to a wound clinic. When asked why the wound had not yet healed, LN #6 said the dressing was soiled a lot related to incontinence and the wound edges were frequently macerated. The LN was asked how measurements were obtained when the dressing was in place, and she said it might mean the dressing was present, then removed. LN #6 said the Wound RN Assessments were done weekly which included wound measurements, and the Wound Date Collections were done daily. The LN said if the dressing was to be changed every 3 days, the nurses would document on the surrounding skin and dressing in between dressing changes.</p> <p>On 10/8/14 at 1:40 p.m., Resident #3's pressure ulcer on the coccyx was observed with LN #6 present. The LN measured the pressure ulcer at 3 x 2 cm with a depth of 0.2 cm. The pressure ulcer was bright pink around the edges and pale in the wound bed. LN #6 said the wound edges were macerated with maybe 20% of slough in the wound bed. The LN was asked how long the</p>	F 314			

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F 314	<p>Continued From page 34</p> <p>resident should be up in the wheelchair, and she stated, "We try to make her last up and first down for meals," but sometimes the resident refused.</p> <p>Resident #3 was admitted to the facility with 2 Stage II pressure ulcers on the coccyx which healed. On 7/3/14, a Stage II pressure ulcer had reopened on the coccyx and orders were received to treat, however, the pressure ulcer was not assessed or treated for 7 days. The initial Care Plan did not contain adequate interventions to prevent pressure ulcers, did not direct staff to reposition the resident, nor did it direct staff how often repositioning should occur. Modifications to the skin care plan were not made until 9/26/14, over 2 months after the Stage II reopened. Wound measurements and characteristics were documented when the dressing was present and intact on 7/11/14 and 8/11/14. The pressure ulcer increased in size significantly on 7/12/14, 7/26/14 and 9/16/14, and the physician was not notified until 9/23/14. Daily Wound Data Collections were not completed from 7/20 - 7/23, 7/27, 8/2, 8/25 - 8/26, 8/28 - 8/29, 9/3 - 9/4 and 9/11/14. Weekly Wound RN Assessments were not completed the weeks of 7/17, 8/14 and 9/18/14.</p> <p>On 10/8/14 at 4:30 p.m., the Administrator and DON were informed of the pressure ulcer issues. No further information or documentation was provided.</p> <p>3. Resident #12 was admitted to the facility on 12/8/12 with multiple diagnoses which included acquired keratoderma and rash.</p> <p>The most recent quarterly MDS assessment, dated 8/20/14, documented Resident #12 was cognitively impaired with a BIMS of 3, required</p>	F 314			

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F 314	<p>Continued From page 35</p> <p>extensive assistance of 2 people for bed mobility, personal hygiene and toilet use, frequently incontinent of bladder and bowel, and no pressure ulcers or skin breakdown.</p> <p>The skin Care Plan documented Resident #12 had the potential for pressure ulcer development related to incontinent associated dermatitis with interventions which included, "Resident prefers to be positioned in the recliner during day and will lay down in bed at night. Has a ROHO cushion in recliner," initiated on 12/3/13 and revised on 5/29/14.</p> <p>Resident #12's September 2014 TAR documented the order, "SilvaSorb Gel (Wound Dressings) Apply to Open area topically one time a day related to RASH AND OTHER NONSPECIFIC SKIN ERUPTION," dated 8/29/14.</p> <p>A Wound Data Collection, dated 8/28/14, documented Resident #12 had a, "pressure area on left buttock" which was not present on admission, and measured 2.0 x 0.2 cm. A description of the wound documented, "whole of buttocks are discolored deep purple but per report this is normal for resident." The wound had 100% granulation tissue, surrounding skin was pink without any open areas, and treatment included, "calmoseptine [sic] vs [versus] dressing."</p> <p>Wound RN Assessments (WRA) and Progress Notes (PN) for Resident #12 documented: * 8/28/14 (WRA) - Pressure ulcer staged at Stage III with modified interventions which included repositioning/turning, support surfaces and wound treatment;</p>	F 314			

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F 314	<p>Continued From page 36</p> <p>* 8/28/14 (PN, MD/Nursing Communications) - "during skin assessment, area on buttock has opened up to a stage II ulcer; will apply dressing and monitor daily; do you want any other treatments done at this time?" The MD said, "Ok, Rx [Treat]..obs[erve]."</p> <p>* 8/29/14 (PN, MD/Nursing Communications) - "[Resident's name] has an open area on her bottom that is 2.0 cm x 0.2 cm x 0.1 cm. May we try silvasorb ointment to it q [every] day to see if we can heal it up? Please advise." The MD said, "Ok[,] obs[erve];"</p> <p>* 9/11/14 (WRA) - Non-pressure wound with tissue loss which decreased in size with no signs and symptoms of infection; and,</p> <p>* 9/17/14 (WRA) - Wound healed, weekly RN assessments were discontinued and, "area is blanchable, red, minimal excoriation noted."</p> <p>On 10/8/14 at 2:40 p.m., LN #6 was interviewed with LN #5 present. LN #6 said Resident #12 ambulated but sat in her recliner most of the time, but agreed to use a bed at night. In addition, the resident was frequently incontinent and was care planned to be toileted every 2 hours while awake, which the CNAss charted on. The resident had occasional excoriation which was treated with Tena cream. LN #6 said she noticed documentation which called the excoriation pressure, so herself and the DON examined the area and felt it was not pressure because it did not have the same consistency as a pressure ulcer. LN #6 stated, "Looks like 9/11 we did a wound assessment." The LN was referred to the Wound RN Assessment which documented the wound as a Stage III pressure ulcer and she stated, "I would say that is an error," and the resident did have discoloration on her buttocks. When asked why the area was only measured</p>	F 314			

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F 314	Continued From page 37 once, the LN stated, "I don't have a good answer for that." LN #6 said the excoriation had healed.  Initial wound assessments on 8/28/14 documented Resident #12 had a Stage III pressure ulcer and provided measurements. The LN said the assessment was inaccurate, however, an assessment to clarify the type of skin breakdown was not done until 9/11/14, 14 days later. The 9/11/14 assessment did not include a rationale as to why the skin breakdown was not pressure related. In addition, the skin breakdown area was only measured once, on 8/28/14, and not measured on 9/11/14.  On 10/8/14 at 4:30 p.m., the Administrator and DON were informed of the inaccurate wound assessment and concerns. No further information or documentation was provided.	F 314		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined	F 315	RECEIVED DEC 04 2014 FACILITY STANDARDS  F tag 315 SS=E 1. a) NA - Resident #3 expired November 4, 2014. b) Resident #4 -- NA - discharged October 25, 2014. c) Resident #6- had a 72 hour bowel and bladder review completed with bowel and bladder assessment. Care plan updated. d) Resident #8 - had a 72 hour bowel and bladder review completed with bowel and bladder assessment. Care plan updated. 2. All residents with occasional or frequent bladder incontinence, as identified by the MDS, have the potential to be affected by this practice and will be audited for bowel and bladder review. 3. Interdisciplinary team will ensure that individualized programs to help residents maintain or restore bladder function will be developed timely. All nursing staff will be re-educated on the process of bowel and bladder review assessment and care plan development. 4. DNS or designee will audit all new admissions, residents with a significant change and annual MDS assessed residents to ensure that bowel and bladder function has been identified and RE-ASSESSED, AND updated as indicated weekly x12 and monthly x3. All audit findings will be reported to QAPI committee monthly for further monitoring and modification.  December 8, 2014	12/11/14 PER 2:40 PM ADMIN.

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F 315	<p>Continued From page 38</p> <p>the facility failed to ensure individualized programs were developed to help residents maintain or restore bladder function. This was true for 4 of 7 residents (#s 3, 4, 6, and 8) sampled for bladder programs. The deficient practice had the potential for harm if residents lost control of remaining bladder function or became embarrassed when incontinent of urine. Findings included:</p> <p>1. Resident #4 was admitted to the facility on 7/17/14 with multiple diagnoses which included a right hip fracture, pressure ulcer to the left hip, and dementia.</p> <p>Resident #4's Admission MDS, dated 7/24/14, coded: *BIMS of 9, indicating moderately impaired cognitive skills; *Extensive assistance of 2 for toileting; *Frequently incontinent of bladder; *No trial toileting program had been attempted; and *No current toileting plan in place.</p> <p>Resident #4's ADL care plan, dated 7/14/14, documented, "Resident requires 2 staff participation to use toilet." Her Incontinence care plan, initiated 7/31/14, documented the size and type of incontinence product the resident used, and that she was to be monitored for signs and symptoms of a bladder infection. There was no further information regarding the resident's voiding patterns, how often she should be toileted, or any special equipment which should be used.</p> <p>On 10/7/14 at 11:55 AM, the surveyor observed the resident inform staff she needed to urinate.</p>	F 315			

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F 315	<p>Continued From page 39</p> <p>The resident was assisted to her room, transferred onto her bed via mechanical lift with 2 person assistance, and placed on a bed pan. Once on the bed pan, the resident stated, "Now I can pee," and voided into the bed pan.</p> <p>2. Resident #6 was admitted to the facility with multiple diagnoses which included CHF and edema.</p> <p>Resident #6's most recent annual MDS, dated 7/7/14, coded: *BIMS of 14, indicating the resident was cognitively intact; *Frequently incontinent of bladder; *No trial toileting program had been attempted; and *No current toileting plan in place.</p> <p>The resident's care plan did not address her incontinence.</p> <p>On 10/6/14 at 10:00 AM, the resident was observed in bed in her room. The resident stated staff did not necessarily offer her the toilet on a regular basis that she was aware of, but knew she could push the call button if she needed anything and the staff would come in and help her.</p> <p>3. Resident #8 was admitted to the facility with multiple diagnoses which included obstructive chronic bronchitis and dementia with delusional features.</p> <p>Resident #8's most recent significant change of condition MDS, dated 9/5/14, coded; , *Long term and short term memory deficits with severely impaired decision making skills;</p>	F 315		

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F 315	<p>Continued From page 40</p> <ul style="list-style-type: none"> <li>*Extensive assistance of 1 for toilet use;</li> <li>*Incontinent of bowel and bladder;</li> <li>*No trial toileting program had been attempted; and</li> <li>*No current toileting plan in place.</li> </ul> <p>Resident #8's ADL care plan documented the resident required 1 person assistance for toilet use. No other information was included in the care plan, such as voiding patterns, how often the resident should be prompted to toilet, or products or special equipment which may be used.</p> <p>On 10/7/14 at 3:05 PM, the DNS was asked about the development of a toileting plan for the residents. The DNS stated when any resident was first admitted to the facility, staff completed a voiding diary for the first 72 hours. At the end of 72 hours, the voiding diary would be forwarded to the care managers, and an individualized toileting plan would be developed from that information. The DNS stated the details for each resident's toileting plan should be documented on the care plan. The DNS could not explain why there was no individualized plan for Resident #s 4, 6, or 8.</p> <p>On 10/8/14 at 4:30 PM, the Administrator, DNS, and LSW were informed of these findings. The facility offered no further information.</p> <p>4. Resident #3 was readmitted to the facility on 2/27/14 with multiple diagnoses which included senile dementia and legal blindness.</p> <p>The most recent quarterly MDS assessment, dated 9/4/14, documented Resident #3 had severe cognitive impairment, required extensive assistance of 2 for toileting, frequently incontinent of bladder, no trial toileting program had been</p>	F 315			

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F 315	<p>Continued From page 41 attempted and no current toileting plan in place.</p> <p>Resident #3's ADL Care Plan, dated 1/13/14, documented the resident required 2 staff participation to use toilet for the transfer. The Incontinence Care Plan, dated 1/28/14, documented the resident had bladder incontinence related to impaired mobility with only one intervention, "BRIEF USE: Resident uses incontinent products."</p> <p>There was no further information regarding Resident #3's voiding patterns, how often she should be toileted, or that she should be checked and changed.</p> <p>On 10/7/14 at 10:10 a.m., the DON said Resident #3 was, "not on a bowel and bladder training program," and somedays the resident was not responsive enough to be toileted. When the resident was more alert, she would at times indicate a need to void, or the staff would prompt her to void. The DON said, "Those [briefs] are checked usually every 2 hours," and agreed that the Incontinence Care Plan did not say anything about toileting or how often.</p> <p>On 10/8/14 at 11:05 a.m., LN #6 said Resident #3 no longer vocalized the need to void, check and changes were done before meals and every 2 hours while in bed, and the staff tried to lay down the resident after meals.</p> <p>The facility failed to develop an individualized incontinence program for Resident #3.</p> <p>On 10/8/14 at 4:30 p.m., the Administrator and DON were informed of the lack of direction in Resident #3's Incontinence Care Plan. No further</p>	F 315			

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F 315 F 318 SS=D	Continued From page 42 information or documentation was provided. 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  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 residents received interventions to prevent a decrease in range of motion (ROM). This was true for 2 of 7 (#s 4 & 7) residents reviewed for ROM, who had the potential to sustain harm when they did not receive services necessary to prevent the deterioration of existing ROM limitations. Findings included:  1. Resident #7 was admitted to the facility on 3/13/13 with multiple diagnoses including cerebral artery occlusion and osteoporosis.  The resident's quarterly MDS assessment dated 9/16/14, documented the resident had an upper extremity ROM limitation.  The resident's ADL care plan had multiple interventions dated 10/7/13, including: - "1. PROM [Passive Range of Motion] R[ight] digits into flexion prolonged stretch (20 [plus]	F 315  F 318	F tag 318 SS=D 1. a) N/A - Resident #4 was discharged on October 25, 2014 b) Resident #7 was reassessed for range of motion (ROM) and care plan updated. 2. All residents requiring range of motion exercises, as identified by therapy and the MDS, to meet their needs have potential to be affected by this practice and will be audited on their programming. 3. The QAPI process identified the root cause as a lapse in the RA program due to staffing. The system change is that all CNAs will be educated to provide restorative interventions as identified on the care plan. The ROM program in care plan is to be documented by the CNA providing care. All Nurses and CNA staff will be trained on range of motion exercises that may be expected of them to help maintain resident's highest level of function. 4. DNS or designee will audit range of motion compliance daily x 5 days, weekly x 3, monthly x 2. All audit findings will be reported to QAPI committee monthly for further monitoring and modification.	December 8, 2014	

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F 318	<p>Continued From page 43</p> <p>seconds) each joint individually...; -2. PROM R wrist flexion hold prolonged 20 [plus] seconds [times] 5; -3. PROM R shoulder...; -4. AAROM [Active Assisted Range of Motion] R shoulder...; -6. AAROM R elbow...; -7. PROM R forearm...; and, Resident has contractures of the R[ight] wrist."</p> <p>The resident's restorative intervention care plan had multiple interventions dated 1/14/14 including: "Nursing Rehab[ilitation] #1: Active range of motion...AROM LE arm elevation...; Nursing Rehab #2:...AROM L pron[ation]...; and, Nursing Rehab #1: Walking from room to therapy room and back as tolerated on days with arms exercises..."</p> <p>On 10/6/14 at 9:32 AM, and on subsequent observations throughout the survey, the resident was observed in her wheelchair with a hand splint to her right wrist.</p> <p>On 10/7/14 at 10:15 AM, the resident was interviewed regarding therapy and ROM issues: When asked about therapy and sitting and standing exercises, the resident stated, "A gal used to work with me, but that ended about a month ago." When asked if staff was doing any ROM exercises with her right hand and arm, she said they were not. She said it would be nice if staff offered to help her do exercises with her.</p> <p>On 10/8/14 at 11:55 AM, the DON was interviewed. When asked if the resident was in physical or occupational therapy, she stated, "Not that I'm aware of." When asked if the resident</p>	F 318			

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F 318	Continued From page 44 was in a ROM program, she stated, "No."  2. Resident #4 was admitted to the facility on 7/17/14 following a fall with a right hip fracture, and a pressure ulcer to her left hip.  Resident #4's admission MDS, dated 7/24/14, coded the resident had impaired range of motion in one of her lower extremities.  Upon record review, no documentation could be found regarding a program to maintain or improve range of motion for her impaired extremity.  On 10/7/14 at 3:05 PM, the DNS stated to the best of her knowledge, the resident was not on a range of motion program. The DNS stated, "Most honestly, it's because we don't have enough staff. We have had to pull the restorative aides to the floor. We have a physical therapy assistant coming in to carry out the programs already in place, but have not initiated any new formalized range of motion programs lately. We will implement more formalized programs again once we are fully staffed."  On 10/8/14 at 4:30 PM, the Administrator, DNS, and LSW were informed of these findings. The facility offered no further information.	F 318		RECEIVED DEC 04 2014 FACILITY STANDARDS	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F tag 323 SS=D 1. Resident # 6 was re-assessed to identify triggers for striking out behavior. Care plan updated. 2. All residents requiring assistance with mobility or supervision have potential to be affected by this practice. 3. The QAPI process identified the root cause as not providing adequate supervision after meals to prevent resident to resident altercations. The system change was the development of a process for supervision of the congested area at nurse's station/lounge after meals. Nurses were educated on the process change. 4. The Social worker or designee will audit supervision provided in congested areas following meals daily x 5, weekly x 3, and monthly x 2. All audit findings will be reported to QAPI committee monthly for further monitoring and modification.	December 8, 2014	

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F 323	Continued From page 45  This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview and record review it was determined the facility failed to ensure residents were protected from resident to resident altercations. This was true for 1 of 8 residents (#6) sampled for resident incidents. The deficient practice had the potential for harm when residents were not protected from a resident known to strike out at other residents. Findings included:  Resident #6 was admitted to the facility on 8/7/12. Her multiple diagnoses included CHF and depression, with recent physician's progress notes documenting diminished memory.  Resident #6's care plan documented a focus area of impaired cognitive function related to dementia on 4/29/14.  Resident #6's most recent annual MDS, dated 7/7/14, coded: *BIMS of 14, indicating the resident was cognitively intact; *Mood severity score of 3, indicating minimal depression; and *No behavioral symptoms.  On 8/26/14, a facility incident report documented Resident #6 was seated in the facility's "living room" next to a resident who was calling out. Resident #6 reached out and began to hit the other resident on the shoulder, and told the other resident to stop screaming.	F 323			

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F 323	<p>Continued From page 46</p> <p>On 8/26/14, Resident #6's care plan documented a new intervention for impaired cognition, "Resident needs reminding that it is not OK to hit other residents when she is upset with them. Contact staff for assistance." There were no interventions to provide increased supervision, or to ensure Resident #6 was not seated next to residents who called out.</p> <p>On 9/23/14 a facility incident report documented, "[Resident #6] was responding to another resident's impulsive vocalizations by striking the resident after each episode. [Resident #6] admitted to striking the resident 'to shut her up.'... 'She wouldn't stop yelling so I hit her to shut her up.'"</p> <p>On 9/23/14, a new focus area was added to Resident #6's care plan, "The resident as a behavior symptom [related to] mood and depression [evidenced by] may strike out at other residents when they startle her or make noises next to her." Interventions included, "Minimize the potential for resident's disruptive behaviors by monitoring who she is sitting next to in the living room. Do not sit next to residents who call out," and, "Assist resident to develop more appropriate methods of coping and interacting such as telling staff when others are bothering her and not slapping out."</p> <p>On 10/6/14 at 10:00 AM, Resident #6 was observed in bed in her room. The resident stated, "I get along with everybody here. I have no problems whatsoever"</p> <p>On 10/8/14 at 8:30 AM, LSW #8 was asked about Resident #6's incidents of striking other residents. LSW #8 stated the 8/26/14 incident could not</p>	F 323			

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F 323	Continued From page 47 have been predicted by the facility, as Resident #6 had never struck out at another resident before. LSW #8 stated that particular incident took place on a weekend, with Resident #6 being startled by another resident who started calling out. LSW #8 stated the other resident involved frequently called out in the mornings. LSW #8 stated the facility felt the new care plan intervention of telling Resident #6 it was not acceptable to slap others was adequate to prevent further occurrences. The LSW was unable to explain how addressing a behavior after it already occurred was considered prevention. The LSW stated the facility was providing increased supervision for Resident #6 after the occurrence, but did not include that intervention in her care plan or document it in any way. The LSW stated "increased supervision" meant that the resident was kept arms' length from residents known to call out. LSW #8 stated the incident on 9/23/14 also occurred in the facility's "living room". After that occurrence, where Resident #6 struck a different resident known for making spontaneous sounds, the care plan was updated to specifically include the approach of keeping Resident #6 at arms' length from "disruptive" residents. The LSW was unable to explain how, if those interventions were in place after the first incident, Resident #6 was able to strike a second resident in the same situation.	F 323			
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION  The facility must provide each resident with	F 327	<p><del>Tag 327</del> SS=D 1. NA - Resident #3 expired. 2. All residents requiring assistance with dining have the potential to be affected by this practice. 3. Orientation developed on resident dining needs prior to non-nursing staff assisting in the dining process. Non-nursing CNA staff will be educated on dining orientation. 4. Dietary Manager and DNS or designee will audit daily x5, weekly x3, and monthly x2. All audit findings will be reported to QAPI committee monthly for further monitoring and modification.</p> <p><i>See next page</i></p>	December 1, 2014	

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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 640 NORTH EISENHOWER STREET MOSCOW, ID 83843	
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F 327	<p>Continued From page 48</p> <p>sufficient fluid intake to maintain proper hydration and health.</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 residents were provided with adequate fluids. This affected 1 of 6 (#3) sampled residents reviewed for hydration, when Resident #3 was not provided with fluids while waiting for a meal to be served. This deficient practice had the potential to cause more than minimal harm if the resident became dehydrated. Findings included:</p> <p>Resident #3 was readmitted to the facility on 2/27/14 with multiple diagnoses which included senile dementia and legal blindness.</p> <p>The most recent quarterly MDS assessment, dated 9/4/14, documented Resident #3 had severe cognitive impairment, impairment to the bilateral lower extremities, and required extensive assistance for eating.</p> <p>Resident #3's Care Plan documented the focus area, "The resident has nutritional problem R/T [related to] malise [sic] and fatigue, nausea with vomitting [sic] E/B [Evidenced by] poor p.o. [By mouth] intake...", with an initiation date of 1/17/14 and revised on 7/23/14. An intervention included, "Provide set up at meals, cue and extensivo assist when needed. Drink preference juice, cocoa, milk, coffee, or tea with meals...", with an initiation date of 1/17/14 and revised on 10/2/14.</p> <p>The October 2014 MRR (recapitulated Physician's Orders) for Resident #3 included the</p>	F 327	<p>F tag 327</p> <p>SS=D</p> <ol style="list-style-type: none"> <li>1. NA - Resident #3 expired.</li> <li>2. All residents requiring assistance with dining have the potential to be affected by this practice.</li> <li>3. The QAPI process identified root cause as being that dining room re-orientation had not been provided to non-nursing CNAs prior to their assisting in the dining room. The systemic change was to develop an orientation on resident dining needs that would be utilized prior to non-nursing CNAs assisting in the dining process. Non-nursing CNA staff were educated on dining orientation.</li> <li>4. Dietary Manager and DNS or designee will audit that residents requiring assistance receive beverages at the same time daily x5, weekly x3, and monthly x2. All audit findings will be reported to QAPI committee monthly for further monitoring and modification.</li> </ol>	December 8, 2014

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F 327	Continued From page 49 order, "Offer fluids every 30 min.[minutes] while awake," with a start date of 8/14/14.  On 10/7/14 at 12:00 p.m., Resident #3 was observed sitting at a table with 3 other residents in the dining room, waiting for the lunch meal to be served. Resident #3 did not have any fluids on the table in front of her, the other 3 residents had been provided fluids. The Health Informations Manager (HIM) was sitting at the table assisting another resident. After Resident #3 received her meal, the HIM provided her with a cup of coffee. No other fluids were provided at that time.  On 10/7/14 at 1:13 p.m., the HIM said whomever set Resident #3 up at the table was responsible for providing fluids, but the HIM did not know who brought the resident to the dining room table.  On 10/7/14 at 1:17 p.m., CNA #7 said kitchen or nursing staff assigned to the dining room would provide drinks to residents.  On 10/7/14 at 1:24 p.m., the DON said the CNA assisting at the table should give drinks to everyone at the table.  On 10/8/14 at 4:30 p.m., the Administrator and DON were informed of the hydration concern. No further information or documentation was provided.	F 327			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections;	F 328	F tag 328 SS=D 1. Resident #3 expired. 2. All residents receiving oxygen therapy have the potential to be affected by this practice. 3. The QAPI process identified the root cause as nursing staff not following the plan of care and removing unnecessary equipment. The system change was that all nursing staff is to remove unnecessary/unused equipment and LN to update CNAs with changes via shift to shift report. All nurses were re-educated on the process of oxygen therapy administration and documentation. 4. DNS or designee to audit accuracy of oxygen orders, care plan, and equipment being used weekly x 4, monthly x2. All audit findings will be reported to QAPI committee monthly for further monitoring and modification.	December 8, 2014	

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F 328	<p>Continued From page 50</p> <p>Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure residents received oxygen per the Physician's order. This affected 1 of 4 (#3) sampled residents reviewed for respiratory care. This created the potential for harm, should residents receive oxygen therapy at different concentrations than ordered by the physician. Findings included:</p> <p>Resident #3 was readmitted to the facility on 2/27/14 with multiple diagnoses which included congestive heart failure.</p> <p>The Care Plan for Resident #3 did not include any information related to respiratory care.</p> <p>Resident #3's September and October 2014 MRR (recapitulated Physician's Orders) documented the order, "O2 [oxygen] at 1-2 Lpm [liters per minute] at noc. at bedtime," with a start date of 3/28/14, and, "...VS [vital signs] every evening shift every Fri[day]," with a start date of 3/7/14.</p> <p>The September and October 2014 Medication Administration Record for Resident #3 documented oxygen had been administered per Physician's order. The vital signs section</p>	F 328			

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F 328	Continued From page 51 documented the following oxygen saturations: * 9/5/14 - 95%; * 9/12/14 - 96%; * 9/19/14 - 100%; * 9/26/14 - 100%; and, * 10/3/14 - 100%.  Resident #3 was observed by the surveyor to have a nasal cannula in place with an oxygen canister, which was set at 2 Lpm, hanging on the back of her wheelchair on the following: * 10/6/14 from 9:43 a.m. until 3:40 p.m.; * 10/7/14 at 10:00 a.m.; and, * 10/8/14 at 8:45 a.m. and 1:40 p.m.  On 10/8/14 at 10:35 a.m., the DON was asked what the oxygen order was for Resident #3. The DON stated, "She's 1-2 liters at night, it says."  On 10/8/14 at 4:30 p.m., the Administrator and DON were informed of the oxygen therapy concern. No further information or documentation was provided.	F 328	F tag 329 SS=E 1. a) Resident #1 - N/A - Resident discharged 11/3/14. b) Resident #3 - N/A - Resident expired 11/4/14. c) Resident #4 - N/A - Resident discharged on 10/25/14. d) Resident #8 re-evaluated for non-pharmacological interventions for behaviors. Care plan updated with personalized interventions. 2. All residents receiving psychoactive medication, as identified by MD orders, have the potential to be affected by this practice and will be audited for target behaviors, non-pharmacological interventions, and double anti-depressant use. 3. QAPI identified the root cause of the deficiency as not identifying all target behaviors or non-pharmacological interventions on the care plan. The system change is that licensed nurses and RN Care managers will ensure that there are adequate indications for use of antipsychotic medications or for the use of multiple antidepressants by documenting daily on MAR (medication administration record). They will ensure that there are clearly identified target behaviors and non-pharmacological interventions and that these are being monitored. All licensed nurses and care plan team will re-educated on the non-pharmacological interventions to be used prior to administration and during use of psychoactive medication. 4. Social service director, DNS or designee to audit for target behaviors, non-pharmacological interventions and double anti-depressant use weekly x4, monthly x3. All audit findings will be reported to QAPI committee monthly for further monitoring and modification.		
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	F 329		December 8, 2014	

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F 329	Continued From page 52 who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility did not ensure adequate indications for the use of antipsychotic medications or for the use of multiple antidepressant medications; did not clearly identify target behaviors or nonpharmacological interventions; and did not monitor for the effectiveness of the medications or adverse side effects. This was true for 4 of 6 residents (#s 1, 3, 4, and 8) sampled for psychotropic medication use. The deficient practice had the potential for harm if residents received medications not needed to treat a specific medical condition, or experienced adverse side effects of those medications. Findings included:  1. Resident #4 was admitted to the facility from an acute care hospital on 7/17/14 with multiple diagnoses which included a right hip fracture, pressure ulcer to the left hip, and dementia.  Resident #4's admission physician's orders to the	F 329			

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F 329	<p>Continued From page 53</p> <p>facility did not document an anti-psychotic medication.</p> <p>Resident #4's 7/24/14 Admission MDS coded: *Moderately impaired cognitive skills; *No hallucinations or delusions; and *Physical behaviors 1 to 3 days out of the past 7 days, which did not place the resident or others at risk of harm or impact the care or social environment.</p> <p>Resident #4's Nurse's Notes (NN) documented the presence of pain, and pain medications given, at least once daily for the month of September, 2014. On most dates, the resident received multiple doses of Tramadol. On 9/9/14, the resident's physician ordered the addition of Hydrocodone 5/325 (5 mg hydrocodone, 325 mg acetaminophen) one-half to one tablet every 2 hours as needed. This medication was documented as given for pain at least once daily throughout the rest of the month.</p> <p>From 9/25/14 to 9/30/14, Resident #4's NNs documented behavioral concerns as follows: *9/25/14 at 11:24 PM, "...had a higher than baseline level of agitation this shift. She spent the hour before meal telling the staff that other residents were being treated poorly and that, 'there should be a law against that'...At mealtime she refused to eat saying, 'I wouldn't feed this garbage to my dog.' Her vocalizations were also out of character repeating phrases like, 'I found my butt' and other nonrelevant topics." 9/26/14 at 2:57 AM, "...agitated, saying loudly...'I want this (the dressing) off!'...taken to the common area in order for us to monitor her...alternately insulting and pleasant." 9/26/14 at 11:44 AM, "...I had an idea about how</p>	F 329			

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F 329	<p>Continued From page 54</p> <p>to cure diabetes. I had a dream and in that dream I said, I got to cure that [expletive] disease.' Resident is pleasant otherwise..."</p> <p>9/26/14 at 9:19 PM, "...[Resident #4] crawled into the hallway and was vocal about feeling persecuted...directed at staff...'You're all trying to kill me'...'I'm the first lady and someone is after me.'" [NOTE: There was no documentation as to whether or not the root cause of this behavioral change was assessed, whether non-pharmacological interventions were attempted, nor how effective those interventions were.]</p> <p>*9/29/14 at 11:41 AM, "...[complained of] pain and requested pain medication but refused to take it upon attempted administration. Attempted several times. Last attempt she yelled out, 'leave me alone, be quiet. I want quiet...'"</p> <p>*9/30/14 at 9:43 AM, "...stated she thought she was dead and that this was heaven. She was glad when she was told she was alive...'I expected heaven to be better than this...'"</p> <p>On 9/30/14 a physician's order for Resident #4 documented Zyprexa 5 mg twice daily as needed for a diagnosis of dementia with behavioral disturbance. There was no documentation as to what the "behavioral disturbance" was, how it was harmful to the resident or others, how persistent the behavior was, how other possible causes to the behavior had been ruled out, or which non-pharmacological interventions had been attempted and determined to be ineffective.</p> <p>On 10/2/14 at 9:24 AM, Resident #4's NN documented, "...demeanor became very unpleasant and socially inappropriate. She was swearing and calling staff verbally inappropriate names. Refused any further pain medication</p>	F 329			

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F 329	<p>Continued From page 55</p> <p>regardless of her statements of 10/10 pain...in between meals rudely demanded several requests, when assistance was provided it was met with refusals and negative verbal expressions...called daughter...on account of [Resident #4's] request...wanting 'get me out of this [expletive] hole..."</p> <p>On 10/2/14 at 5:29 PM, Resident #4's MAR documented she was given a dose of Zyprexa. The resident's eAdministration record for that medication documented, "Administered for instance of increased fear and related verbal abuse towards staff." No further information was documented.</p> <p>On 10/4/14 at 5:50 PM. Resident #4's MAR documented she was given a dose of Zyprexa. The eAdministration record documented no specific behavioral event occurring at the time which warranted the use of the medication.</p> <p>On 10/7/14 at 11:20 AM, Resident #4 was observed in the day room near the nurse's station. She was sitting in her wheelchair at an over bed table. Her eyes were closed with her hands folded in her lap. A blanket covered her legs. At 11:22 AM, the resident folded her arms on the over bed table, and laid her head down on top of her arms. After a few minutes, she lifted her head, thrust her tongue out of her mouth twice to lick her lips, then closed her eyes and lowered her head. After approximately 1 minute, she lifted her head again and clutched her abdomen. She did not speak during this time, and did not move except as described.</p> <p>On 10/7/14 at 11:27 AM, Resident #4's MAR documented she was given a dose of Zyprexa.</p>	F 329			

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F 329	Continued From page 56  On 10/7/14 at 11:55 AM, she was taken to her room, transferred via mechanical lift to her bed, had her incontinence brief changed, and transferred back to her wheelchair. Throughout this time, she was calm and pleasant, expressing her gratitude towards the staff caring for her, and joking with them.  On 10/7/14 at 3:05 PM, the DNS was asked about Resident #4's behaviors and Zyprexa use. The DNS stated Zyprexa would be used for Resident #4 if her behavior was "not her normal swearing, but really fearful, like crawling on the floor or if she was in a mood where she just wants to be dead, and is not alterable with the use of a warm blanket or a pain pill. Then I would use the PRN Zyprexa and let the physician know we needed something better." The DNS stated there was no specific behavior tracked for this resident, or for the use of the Zyprexa, but the CNAs had the opportunity to document on general resident behavior each shift. The DNS stated the licensed nurses should also chart with a narrative note whenever they used the medication. The DNS stated she was aware the use of Zyprexa on an "as needed" basis was not ideal, but the resident's physician had felt the order was appropriate for this resident. However, the DNS could not provide documentation of the reasoning behind the physician's assessment.  2. Resident #8 was admitted to the facility in 2010 following a hip fracture, and also had a diagnosis of dementia with behavioral disturbances.  On 7/18/14, a pharmacy recommendation for Resident #8 documented the resident was receiving Risperdal 0.25 mg daily routinely, and	F 329			

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F 329	<p>Continued From page 57</p> <p>could have another 0.25 dose as needed for a diagnosis of senile dementia with delusional features. The recommendation documented requested the physician provide documentation of other interventions attempted to manage the resident's behaviors, and that the physician provide documentation that the benefits of the medication outweighed the risk in terms of an FDA black box warning of serious and potential fatal side effects of the use of this medication. The MD responded that the medication was prescribed by "psychology", and deferred the recommendations to that practitioner.</p> <p>On 8/27/14, a Behavioral Health Progress note documented the resident's "Chief Complaint" as, "I can't stop it (yelling). Someone needs to help me." The instructions section of the form documented to continue the routine dose of Risperdal, but avoid using the PRN dose if possible.</p> <p>On 9/5/14, Resident #8's change of condition MDS coded: *No change in cognition, previously assessed as long and short term memory deficits and severely impaired decision making skills; and *No hallucinations, delusions, or other behavioral symptoms.</p> <p>On 9/16/14, a "Quick Note" from the behavioral health practitioner documented the discontinuation of the resident's Risperdal. A NN from that date documented, "...[Mental Health Practitioner] reported her goal is to start [the resident] on Seroquel however she wants him off the Risperidone [Risperdal] first..."</p> <p>Following the discontinuation of Resident #8's</p>	F 329			

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F 329	<p>Continued From page 58</p> <p>Risperdal, the NNs documented: *9/17/14 at 5:57 AM, "[Resident #8] was quiet all shift until about 4 AM, when he began yelling that he had to poop. [Resident #8] had a [bowel movement] yesterday." There was no documentation as to whether the resident was taken to the bathroom at that time, nor if he indeed had to have a bowel movement. *9/18/14 at 10:17 AM, "...[Resident] yelling, "Somebody help me!" CNA asked, 'How can I help you?' He stated, 'I'm playing with my ball, help me.'...Assisted out of bed and was appropriate during breakfast..." *9/22/14 at 3:07 PM, "[Resident] yelling all shift, "Somebody help me. Who is gonna help [Resident #8's name]...redirected to watch TV but would only do that for a few minutes...refuses to get up out of bed to go for a walk or sit in lounge..." *9/23/14 at 1:27 PM, "[Resident] had constant yelling and calling out. Medicated X 1 for pain but [resident] continued to yell..." *9/25/14 at 1:57 PM, "...Had several incidents of yelling and calling out. Disrupted other residents...taken to his room per his request...once in bed...stopped yelling." 9/26/14 at 2:52 PM, "[Resident] had episodes of yelling and screaming in bed and when up for meals. Was medicated for pain X 1." *On 9/30/14 at 12:57 PM, "...Seroquel 25 [milligrams by mouth twice daily] for dementia with delusions. NP [Nurse Practitioner] informed this RN that medication may make [resident] lethargic and that family is aware and OK with this side effect..."</p> <p>There was only documentation of resident behaviors on 6 of the 14 days between the time the resident's Risperdal was discontinued, and</p>	F 329			

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F 329	<p>Continued From page 59</p> <p>the time his Seroquel was started. There was not consistent documentation of the nonpharmacological interventions used, and those which were documented were at times effective in altering the resident's yelling out.</p> <p>On 10/8/14 at 8:30 AM LSW #8 stated Resident #8 had a behavior of calling out, which could be disruptive to other residents and cause them to act out towards Resident #8. The LSW stated she was not sure why the resident called out, but it seemed to be worse in the mornings and could at times be altered by taking the resident outside or engaging him in conversation about farming. The LSW stated the resident saw a counselor weekly, but the counselor had not provided any recommendations to be incorporated into the resident's care plan. The LSW stated she would have to research why the resident was started on Seroquel.</p> <p>On 10/8/14 the DNS stated there would be no specific monitoring for a target behavior for Resident #8 related to Seroquel use, but the CNAs could document behaviors via the ADL sheets if they occurred.</p> <p>The Mood Tracking portion of Resident #8's ADL flow record for September 2014 was blank, indicating no target behaviors had occurred.</p> <p>On 10/8/14 at 11:45 AM, LSW #8 referred to the mental health practitioner's note from 9/16/14 which documented the intent to start the resident on Seroquel. The LSW stated she believed this was at the request of the resident's family.</p> <p>On 10/8/14 at 4:30 PM, the Administrator, DNS, and LSW were informed of these findings. The</p>	F 329			

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F 329	<p>Continued From page 60 facility offered no further information.</p> <p>3. Resident #1 was readmitted to the facility on 7/30/14 with multiple diagnoses which included anxiety state and depressive disorder.</p> <p>The most recent admission MDS assessment, dated 8/6/14, documented Resident #1 had no depression with a score of 0, and verbal behavioral symptoms directed toward others occurred 1 to 3 days which did not place the resident or others at risk of harm or impact the care or social environment. The assessment triggered the Care Area Assessment (CAA) for psychotropic drug use.</p> <p>Resident #1's Care Plan documented the focus, "[Resident's name] has a mood problem R/T [related to] anxiety and depressive disorder E/B [evidenced by] unable to remember family has visited and laments that family does not come to see her...", initiated on 7/31/14 and revised on 8/5/14. The intervention documented, "Provide encouragement/assistance/support to maintain as much independence and control as possible," with a date of 7/31/14.</p> <p>The October 2014 MRR (recapitulated Physician's Orders) documented 2 antidepressant medications for Resident #1 which included, "Mirtazapine Tablet Give 15 mg by mouth at bedtime related to DEPRESSIVE DISORDER NOT ELSEWHERE CLASSIFIED," with a start date of 7/30/14 and, "FLUoxetine HCl Tablet Give 30 mg by mouth two times a day related to DEPRESSIVE DISORDER NOT ELSEWHERE CLASSIFIED," with a start date of 9/16/14.</p>	F 329			

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F 329	<p>Continued From page 61</p> <p>The MAR for October 2014 documented Resident #1 received the 2 antidepressant medications as ordered.</p> <p>The facility failed to ensure clinical rationale for use of antidepressant duplicate therapy, monitor adverse side effects, and individualize Resident #1's Care Plan for psychopharmacological drug use or behavior management.</p> <p>On 10/7/14 at 11:00 a.m., the DON was interviewed regarding Resident #1. The DON said since the resident's stroke, she had more lability with her mood and was started on medication which helped the resident be less anxious. The intervention would be interpreted as talking about positive goals and reassuring the resident. The DON was informed the triggered CAA for psychotropic drug use was not on the Care Plan and she stated, "It doesn't say the use of antidepressants." The DON was asked how the adverse side effects of the antidepressants were monitored, and she referred to the Chart Codes/Follow Up Codes on the bottom strip of the MAR and said, "Not on [the] care plan what the side effects are." For behavior and mood monitoring, the DON said she would look at the mood review spreadsheet. When asked about the clinical justification for use of the 2 antidepressant medications she stated, "I'd have to look it up and see."</p> <p>On 10/8/14 at 4:30 p.m., the Administrator and DON were informed of the concerns with antidepressant medications. No further information or documentation was provided.</p> <p>4. Resident #3 was readmitted to the facility on 2/27/14 with multiple diagnoses which included</p>	F 329		

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F 329	<p>Continued From page 62</p> <p>depressive disorder and senile dementia with delusional features.</p> <p>The most recent quarterly MDS assessment, dated 9/4/14, documented Resident #3 had mild depression with a score of 4, hallucinations and delusions.</p> <p>Resident #3's Care Plan documented the focus, "[Resident's name] has a mood problem R/T depressive disorder, inability to remember where she is, hallucinations that cause fear E/B need for antidepressant medication [sic] and hx, fearful screams when hallucinating," initiated on 1/17/14 and revised on 7/3/14. Interventions included, "Provide encouragement/assistance/support to maintain as much independence and control as possible," initiated on 1/17/14 and, "NON-PHARMACOLOGICAL: Attempt non-pharmacological interventions when fearful-calmly soothe her and reorient to time and place, reassure she is safe," initiated on 6/10/14 and revised on 7/3/14.</p> <p>An additional focus area on Resident #3's Care Plan documented, "The resident uses antidepressant medication R/T Depression," initiated on 1/28/14. Interventions included, "Education resident/family about risks, benefits and the side effects and/or toxic symptoms of medication; Discuss with health care provider, family ongoing need for use of medication; Consult with pharmacy, health care provider to consider dosage reduction when clinically appropriate."</p> <p>The October 2014 Medication Review Report for Resident #3 documented, "Zoloft Tablet (Sertraline HCl) Give 100 mg by mouth one time</p>	F 329		

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F 329	<p>Continued From page 63</p> <p>a day related to DEPRESSIVE DISORDER NOT ELSEWHERE CLASSIFIED," which was started on 8/15/14.</p> <p>The October 2014 MAR documented Resident #3 received the antidepressant medication as ordered.</p> <p>On 10/7/14 at 10:10 a.m., the DON was interviewed. She said when Resident #3 was first admitted she slapped people, had hallucinations where she talked to people who weren't there, and was resistive to cares, especially during hallucinations. The DON said Social Services dealt with hallucination management and stated, "There aren't specific instructions [on the care plan] on how to deal with it." When asked how behaviors were monitored, the DON stated, "The CNAs have a tab [in the computer system] to identify it there." She said documentation for adverse side effects related to antidepressant medication would be on the bottom of the MAR, but there was no place to document it on the MAR. After the DON reviewed Resident #3's MAR she stated, "I may be thinking of our old system. I don't see it on these." The DON was asked what the Care Plan documented about adverse side effects and she stated, "It doesn't. Just talks about non-pharmacological interventions on that."</p> <p>Resident #3's Care Plan did not direct staff to monitor target behaviors and did not provide specific instructions for behavior management. Review of the medical record did not provide evidence of consistent behavior monitoring from the nursing staff. In addition, the Care Plan did not instruct staff to monitor for adverse side effects, did not list the side effects, and the</p>	F 329			

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F 329	Continued From page 64 medical record lacked documentation adverse side effects were monitored.	F 329		
F 353 SS=E	On 10/8/14 at 4:30 p.m., the Administrator and DON were informed of the antidepressant concerns. No further information or documentation was provided.  483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS  The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.  The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:  Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.  Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.  This REQUIREMENT is not met as evidenced by: Based on observation, resident/resident group and staff interviews, interviews with resident family members, and record review, it was	F 353	F tag 353 SS=E 1. a) N/A - Resident #1 discharged; b) Resident #2 -- See POC for F312 and F514; c) N/A -- Resident #3 expired; d) N/A -- Resident #4 discharged; e) Resident #5 -- See POC for F242, F280, and F309; f) #6 -- See POC for F280, F309, F 315 and F323; g) #7 -- See POC for F248, F280, F318 and F541; h) #8 -- See POC for F315 and F329; 2. All residents have the potential to be affected by this practice. 3. Staffing needs have been evaluated to identify trends resulting in CNA shortage in the area; Staff wages were evaluated and adjusted 9/29/2014. Incentive programs were developed and job advertisement options explored, as well as the development of the facility's own CNA course to promote recruitment of staff. 4. DNS or designee will audit staffing needs weekly x16 to insure adequate nursing staff is scheduled to provide patient care. All audit findings will be reported to QAPI committee monthly for further monitoring and modification.	December 1, 2014 12-8-14 Per Admin 12-4-14 D.S.

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F 353	<p>Continued From page 65</p> <p>determined the facility did not ensure sufficient staff to meet resident needs. This was true for 8 of 12 sampled residents (#s 1 - 8), and had the potential to impact any resident in the facility. The lack of sufficient staff created the potential for residents to not have their needs met. Findings included:</p> <p>1. Initial Tour</p> <p>On Sunday 10/5/14 at 3:15 PM, the surveyors entered the facility to begin the survey. Staff members and residents were interviewed regarding the availability of staff on the weekends.</p> <p>*One resident reported the facility was "too short staffed", and that it was not uncommon to wait for 30 minutes before someone responded to his/her call light. If two staff were required to assist with his/her need, "I don't get it." Another resident stated on a weekend, he/she typically waited up to an hour for call light response times.</p> <p>*One CNA reported there had been a call in that day, and the facility had been unable to find someone to cover the shift so, "right now it's not too good."</p> <p>*One CNA reported he/she was responsible to assist residents both on the special care unit, and on the regular nursing care unit. The CNA stated the facility normally liked to have CNAs designated to either one unit or the other. The CNA stated his/her current assignment made it difficult, because there was a set of closed doors between the two areas to which he/she was assigned, so residents may be in need but he/she had no way of telling.</p> <p>*An LN reported he/she noticed a direct correlation between facility staffing levels and resident behaviors. "When staffing goes down,</p>	F 353			

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F 353	<p>Continued From page 66 behaviors go up." *At 3:30 PM, the Administrator arrived in the facility. She reported the facility had difficulties with staffing, which were related to the seasonal nature of the labor pool in the area. The Administrator stated each summer and fall there was an influx and outflux of staff due to the community being a "college town." The Administrator stated, "This year, we did not get the number of applications in the fall like we normally do. In fact, we stopped admitting new residents about three weeks ago, until we can get some more staff hired." The Administrator stated the facility was actively working to resolve the issue.</p> <p>2. Resident Group Interview</p> <p>On 10/6/14 at 1:30 PM, the surveyors met with the resident group. Six of seven residents in the group expressed concern about the level of staffing in the facility, as well as the amount of staff turnover. The residents stated new staff were not as efficient as seasoned staff, and they were concerned the facility did not have time to train the newer staff members sufficiently before they had to work the floor independently. The residents identified they would like to have 1 to 2 more CNAs per shift, to help answer call lights more timely, and to ensure meal trays were passed timely. The group stated the facility was aware of their concerns, and was working on a resolution.</p> <p>3. Family Interviews</p> <p>On 10/6/14 at 2:30 PM, two resident family members requested to meet with the surveyors. The family members stated they wanted to make</p>	F 353			

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F 353	<p>Continued From page 67</p> <p>sure the survey team was aware the facility did not have enough staff. While they were sensitive to the nature of the labor pool in the community, the resident family members stated, "They should have seen it coming. Young people leaving to go back to school happens every year." The resident family members stated they had started coming to the facility daily to stay with their loved ones, usually from lunch time through bed time, to assist their loved ones to eat and make sure staff were helping them with other needs, such as repositioning and toileting, when needed.</p> <p>4. Quality of Care Issues Identified By the Survey Team</p> <p>*The facility did not have adequate staff to execute care plans for all residents, or to ensure individualized, person-centered care for residents with dementia. Please see F 309 for details. *The facility was not able to provide showers or baths to all residents routinely. Please see F 312 for details. *The facility failed to prevent the development of pressure ulcers. Please see F 314 for details. *The facility did not have individualized toileting programs to help residents maintain or restore bladder continence. Please see F 315 for details. *The facility either did not initiate, or did not carry out, range of motion programs for all residents in need. Please see F 318 for details. *The facility did not ensure adequate supervision to prevent resident to resident altercations. Please see F 323 for details. *The facility did not ensure a resident received fluids per his/her plan of care. Please see F 327 for details. *The facility did not administer oxygen as ordered by a resident's physician. Please see F 328 for</p>	F 353			

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F 353	<p>Continued From page 68 details.</p> <p>*The facility did not ensure adequate indication for use or monitoring before using psychotropic medications for residents with dementia-related behaviors. Please see F 329 for details.</p> <p><b>5. Impact on Ancillary Services for Residents</b></p> <p>During the course of the survey, it was determined the facility was utilizing non-nursing personnel to carry out some duties normally assigned to the nursing department. As a result, there were additional deficiencies identified in some of those areas. Please see F 241 and F 248 for details.</p> <p><b>6. Quality Assurance</b></p> <p>On 10/8/14 at 2:45 PM, the Administrator and DNS were interviewed about facility staffing, as part of the Quality Assurance task. They stated the facility had identified potential issues with nursing staff availability, even before resident care was impacted, due to multiple staff giving notice that they were leaving, and a lack of applications to hire new staff. Once this discovery was made, the facility responded by limiting new admissions to the facility. The Administrator stated the facility had only admitted 2 new residents in the past 3 weeks. Since the staffing concerns were identified, the facility had raised salaries and offered sign-on bonuses in an effort to attract and retain staff, started a CNA class, and consulted existing staff for suggestions as to how the facility could support them in providing good resident care. The Administrator stated the use of non-nursing personnel to help with meals and answering call lights arose from those suggestions, and it seemed most crucial at the</p>	F 353		

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F 353	Continued From page 69 time to focus on direct resident care needs. The Administrator stated she was aware of the challenges with carrying out range of motion programs, and the facility had engaged the services of a physical therapy assistant to conduct programs already in place. The Administrator stated the facility had budgeted for a greater ratio of staff to residents for the upcoming year. The Administrator and DNS stated they planned to continue to work on the staffing issue until it could be resolved.	F 353			
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based on the Resident Group Interview, resident interviews, test tray evaluation and staff interview, it was determined the facility failed to prepare palatable food. This affected 5 of 8 residents who attended the Resident Group Interview, 2 random residents, and had the potential to affect other residents who dined in the facility. This failed practice created the potential to negatively affect the resident's nutrition status and psychosocial well-being. Findings included:  On 10/5/14, during interviews with two residents who wished to remain anonymous, one resident said the food was terrible. The other resident covered his/her mouth with a hand, while making	F 364	F tag 364 SS=E 1. On 10/7/14, Dietary Manager re-temped food at point of service and temps were within acceptable limits. 2. All residents have potential to be affected by this practice. 3. Cook to temp at point of service; temps are taken each meal and documented. Any foods removed from dining area for service in building will be set up to maintain acceptable serving temps for palatability. Dietary staff will be re-educated on changes in the process and expectations of compliance. 4. Dietary Manager or designee, will audit test trays daily x5, weekly x 3, bi-weekly x 1 months and monthly x 3. All audit findings will be reported to QAPI committee monthly for further monitoring and modification.	December 4, 2014 12-8-14 Per Admin 12-4-14 D.S.	

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F 364	Continued From page 70 a gagging sound and then stated, "It's not good."  On 10/6/14 at 1:30 PM, during the Resident Group Interview, 5 out of 8 residents had the following complaints about the food: -Breakfast and supper were not good; -Too much soup and sandwiches; -The soup was too thick; -The Bacon was too thin; -Pancakes were cold and not cooked evenly; and, -The toast was soggy. Three of 8 residents did not like peppers in their eggs. One of the residents said he sends his tray back frequently due to the issues listed above.  On 10/7/14 at 6:10 PM, a dinner meal test tray was evaluated by the survey team and the facility Dietary Manager (DM). The test tray included a fried fish sandwich, french fries, coleslaw, and a fruit cup. The french fries were determined to be unpalatable, were not warm enough and were tough.  On 10/7/14 at 6:15 PM, the DM was asked what she thought of the french fries and she stated they were, "a little tough."  On 10/8/14 at 4:45 PM, the Administrator and DON were informed of the issues. No further information was provided.	F 364			
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	F 371	F tag 371 SS=F 1. Scarred plates removed from service. Director of Maintenance adjusted water mix valve under sink to bring water to acceptable temperature on October 5, 2014. 2. All residents have the potential to be affected. 3. Discontinue use of lipped plates. Stainless steel plate guards ordered on October 22, 2014. Staff educated on use of guards, which were placed into service October 31, 2014. Dietary Manager or designee will audit all residents requiring assistive dining plates, adjust care plan to reflect change. Water mix valve adjusted to provide acceptable temperature water. 4. Dietary Manager or designee will audit water temperature daily x 5, weekly x 3, monthly x 3. All audit findings will be reported to QAPI committee monthly for further monitoring and modification.	Per Admin 12.4.14 D.S.  12.8.14 December 1, 2014	

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F 371	<p>Continued From page 71</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure hot water was available for the designated handwashing sink in the kitchen and plastic lipped plates used by residents were able to be sanitized. This was true for 12 of 12 sampled residents (Resident #s 1-12) and any resident eating food prepared in the facility's kitchen. The deficient practice had the potential to cause minimal harm if a resident developed a food-bourne illness from improper handwashing or the use of scratched plates in the kitchen. Findings included:</p> <p>1. The State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities, under F 371 documented, "...staff involved in food preparation...should have access to proper hand washing facilities with...hot water..."</p> <p>On 10/5/14 at 4:20 PM, Cook #2 was observed to wash his hands in the only handwashing sink in the kitchen for at least 20 seconds. The surveyor then washed his hands for 20 seconds and the water was cool to the touch. Note: The water was turned on by pressing a knee or leg against a pressure pad below the sink. The operator did not have control of the water temperature. The Dietary Manager (DM) was interviewed immediately after the handwashing and she</p>	F 371		

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F 371	Continued From page 72 stated, "It takes a long time to have hot to get here." The water was tested by the DM and it was only 66 degrees Fahrenheit (F).  2. On 10/7/14 at 11:22 AM, a container of cleaned plastic lipped plates were observed. Four of plates observed, contained scratches and gouges over the entire eating surface. The DM stated, "These are scratched...I will throw them away." The DM was observed to throw the plates in the garbage.  The 2009 FDA Food Code, Chapter 4, part 4-2, Design and Construction, Subpart 202.11 Cleanability, indicated, "(A) Multituse Food contact surfaces shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, inclusions, pits, and similar imperfections..."  On 10/8/14 at 4:45 PM, the Administrator and DON were informed of the issues. No further information was provided by the facility.	F 371			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431	F tag 431 SS=D 1. Upon notification, pharmacy was notified and immediately addressed by adding the dosage to the label. When new drugs were received on October 10 2014, all medications had dosage on the label. 2. All residents have potential to be affected by this practice. All medication labels have been reviewed to insure dosage is on label. 3. On receipt of all medications from pharmacy, nursing will check every label to insure dosage is on label. Nursing will return medication to pharmacy for addition of dosage to medication label. Licensed nurses will be re-educated to the change in this process. 4. DNS or designee will audit that all medications have dosage on the label weekly x 2 weeks, bi-weekly x 3, monthly x 2. All audit findings will be reported to QAPI committee monthly for further monitoring and modification.		Per Admin 12-4-14 D.S. 12-8-14 December 2, 2014

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F 431	<p>Continued From page 73 instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure medications had the dosage on the medication label. This was true for 1 of 8 (#15) residents during the medication pass observation. This deficient practice created the potential for harm if the resident received the wrong dose of medication. Findings included:</p> <p>The October 2014 MRR (recapitulated Physician's Orders) for Resident #15 documented the orders, "Calcium-Vitamin D Tablet 500-200 MG-UNIT (Calcium Carbonate-Vitamin D) Give 1 tablet by mouth two times a day..." and, "Glucosamine-Chondroitin Tablet 750-600 MG Give 1 tablet by mouth two times a day..."</p>	F 431		

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F 431	Continued From page 74  The October 2014 MRR documented Resident #15 received the medications as ordered.  On 10/7/14 at 4:50 p.m., LN #9 was observed as Resident #15's medications were poured which included Calcium-Vitamin D and Glucosamine-Chondroitin. The labels on the medications documented, "OYSTER SHELL /D 500 MG TAB," and, "GLUCOSAMINE/CHONDROITIN/MSM." The Calcium and Vitamin D label did not include the full dosage, and the glucosamine/chondroitin label did not include the dosage. LN #9 said the labels were from a different pharmacy.  On 10/8/14 at 3:45 p.m., the DON was asked how the nurses knew the dosage was correct when administering Resident #15's medications, when the label did not display the dosage. After the DON reviewed the medication labels, she stated, "I don't know."  On 10/8/14 at 4:30 p.m., the Administrator and DON were informed of the labeling concern. No information or documentation was provided.	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441	F tag 441 SS=D 1. CNA #4 was re-educated on hand hygiene during patient care. LN #10 will be re-educated on the storage and emptying of urinals. 2. All residents have the potential to be affected by this practice. 3. Re-education of all nursing staff on hand hygiene and urinal storage and emptying. 4. Infection preventionist or designee to audit hand washing and urinals daily x5, weekly x3, monthly x2. All audit findings will be reported to QAPI committee monthly for further monitoring and modification.	Per Admin 12.4.14 D.S.  12.8.14 December 2014	

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F 441	<p>Continued From page 75</p> <p>(1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure proper hand washing during resident care and failed to ensure a resident's urinal was emptied and stored appropriately. This was true for 1 sampled Resident (#4) and 1 Random Resident (#16). This practice had the potential for residents to develop infections. Findings included:</p>	F 441			

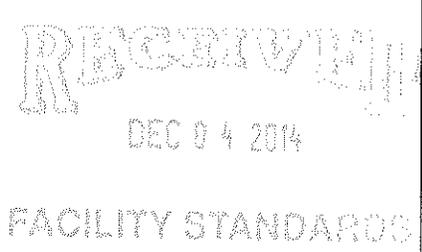
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F 441	<p>Continued From page 76</p> <p>1. On 10/7/14 at 11:55 AM. CNA # 3 and CNA #4 were observed assisting Resident # 4 to use the bedpan and changed the resident's incontinence brief. Both CNAs used hand sanitizer gel and applied gloves before removing the resident's incontinence brief. The incontinence brief was soiled with feces. The CNA #4 removed the soiled attends and cleaned the resident's peri area with wipes. Wearing the same gloves and without performing hand hygiene, CNA #4 assisted CNA #3 to roll the resident side to side so as to be placed on the bedpan. The resident urinated in the bedpan. Once the resident had finished, CNA #4 removed the bedpan, took it into the bathroom to empty it, and returned to the resident. CNA #4 applied a clean incontinence brief. Both CNAs then pulled up the residents pants, placed a sling for the mechanical lift under her, and used the lift to transfer the resident to a wheelchair. Neither CNA changed gloves or performed hand hygiene after the observation of the brief being removed. After the resident was positioned in the wheelchair, both CNAs removed their gloves and used hand sanitizer gel.</p> <p>On 10/7/14 at 12:10 PM, the CNAs were asked about hand hygiene during cares for Resident #4. CNA #4 tapped herself on the forehead with her hand and stated, "Darn it. It was just a brain lapse. Nerves."</p> <p>On 10/8/14 at 4:45 PM, the Administrator, DNS and LSW were informed of these findings. The facility offered no further information.</p> <p>2. On 10/7/14 at 5:15 p.m., LN #10 was observed while administering medication to Resident #16. A plastic urinal filled with urine was observed on Resident #16's bedside table next to a water</p>	F 441			

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F 441	Continued From page 77 pitcher, a disposable coffee cup, a hair brush and comb. The LN left the room and did not empty the urinal.  On 10/8/14 at 3:45 p.m., the DON was asked about urinals filled with urine on bedside tables. She said the urinal shouldn't be on the bedside table, and if the urinal contained urine it should be emptied right away and the table wiped down.  On 10/8/14 at 4:30 p.m., the Administrator and DON were informed of the urinal concern. No information or documentation was provided.	F 441	 <p>F tag 514 SS=D 1. a) N/A - Resident #1 was discharged November 3, 2014. b) N/A - Resident #3 expired. c) Resident # 7 - MD orders for PT and massage therapy were updated. 2. All residents have the potential to be affected by this practice. 3. A process will be developed for all nurses to insure documentation is complete prior to leaving from shift. All licensed nurses will be re-educated on completion of physician orders and documentation as indicated. 4. DNS or designee will audit MAR and TAR (treatment administration record) documentation and accuracy of MD orders daily x5, weekly x7, and monthly x2. All audit findings will be reported to QAPI committee monthly for further monitoring and modification.</p>		
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 staff interview and record review, it was determined the facility failed to ensure residents' recapitulated Physician's orders and Treatment Administration Records were complete and accurate. This was true for 3 of 12 (#s 1, 3 &	F 514			December 8, 2014

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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 640 NORTH EISENHOWER STREET MOSCOW, ID 83843		
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F 514	<p>Continued From page 78</p> <p>7) sampled residents. This created the potential for medical decisions to be on based on inaccurate information. Findings included:</p> <p>1. Resident #1's TAR for August, September and October 2014 documented orders to assess pain every shift and to rate the pain 0-10, monitor number of hours resident slept per shift, and assess skin, edema, lungs, bowels and vital signs.</p> <p>Pain was not assessed or rated on 8/3 day shift, 8/13 day shift, 8/17 evening shift, 8/31 day shift, 9/14 night shift and 10/4 day shift. Number of hours slept were not documented on 8/31 day shift, 9/14 night shift and 10/4 day shift. The assessment of skin, edema, lungs, bowels and vital signs were not documented on 10/4.</p> <p>2. Resident #3's TAR for August, September and October 2014 documented orders to assess pain every shift and to rate the pain 0-10.</p> <p>Pain was not assessed or rated on 8/17 evening shift, 9/14 night shift, 9/21 evening shift and 10/4 day shift.</p> <p>On 10/8/14 at 3:45 p.m., the DON was asked what the blank boxes meant on the TAR. She stated, "That means they weren't done."</p> <p>3. Resident #7 was admitted to the facility on 3/13/13 with multiple diagnoses including cerebral artery occlusion and osteoporosis.</p> <p>The resident's October 2014 Order Summary Report documented an order on 8/26/14, "PT [Physical Therapy] or massage therapy to neck." There was no discontinue date on the report.</p>	F 514			

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

PRINTED: 10/31/2014  
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>C</b> <b>10/09/2014</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 79</p> <p>The resident's Physical Therapy Discharge Summary dated 9/22/14, documented, "...Patient has progressed to the point that she no longer requires skilled intervention..."</p> <p>On 10/8/14 at 3:40 PM, the DON was interviewed regarding the PT discrepancy. When asked if there was a PT discharge order, she stated, "There should have been."</p> <p>On 10/8/14 at 4:45 PM, the Administrator and DON were informed of the documentation issues. No further information was provided by the facility.</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>C</b> <b>10/09/2014</b>
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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>
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C 000	16.03.02 INITIAL COMMENTS  The following are the results of the State Licensure and complaint survey for the facility. The team entered the facility on 10/5/14 and exited on 10/9/14. Members of the survey team were:  Nina Sanderson, LSW, BSW - Team Coordinator Brad Perry, LSW, BSW Lauren Hoard, RN, BSN	C 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.	
C 111	02.100,02,f Provide for Sufficient/Qualified Staff  f. The administrator shall be responsible for providing sufficient and qualified staff to carry out all of the basic services offered by the facility, i.e., food services, housekeeping, maintenance, nursing, laundry, etc. This REQUIREMENT is not met as evidenced by: Please see F 353 as it pertains to facility staffing.	C 111	C 111 Refer to response to F-353	
C 125	02.100,03,c,ix Treated with Respect/Dignity  ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F241 as it relates to assisting residents to dine with dignity.	C 125	C 125 Refer to response to F-241	
C 147	02.100,05,g Prohibited Uses of Chemical Restraints  g. Chemical restraints shall not be	C 147	C 147 Refer to response to F-329	December 8, 2014

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FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Jani Berg</i>	TITLE  <i>Administrator</i>	(X6) DATE  <i>11-6-14</i>
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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>C</b> <b>10/09/2014</b>
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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>
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C 147	Continued From page 1  used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician. This Rule is not met as evidenced by: Please see F 329 as it pertains to psychotropic medication use.	C 147		
C 311	02.107,07 FOOD PREPARATION AND SERVICE  07. Food Preparation and Service. Foods shall be prepared by methods that conserve nutritive value, flavor and appearance, and shall be attractively served at proper temperatures. This Rule is not met as evidenced by: Refer to F364 regarding food palatability.	C 311	C 311 Refer to response to F-364	
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 for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Refer to F371 regarding kitchen handwashing sink temperature and scratched plates.	C 325	C 325 Refer to response to F-371	December 8, 2014 <i>dy</i>

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001510	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/09/2014
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - MOSCOW VILL	STREET ADDRESS, CITY, STATE, ZIP CODE 640 NORTH EISENHOWER STREET MOSCOW, ID 83843
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C 643	Continued From page 2	C 643		
C 643	02.150,01 INFECTION CONTROL  150. INFECTION CONTROL.  01. Policies and Procedures. Policies and procedures shall be written which govern the prevention, control and investigation of infections. They shall include at least: This Rule is not met as evidenced by: Please see F 441 as it pertains to infection control.	C 643	C 643 Refer to response to F-441	
C 674	02.151,01 ACTIVITIES PROGRAM  151. ACTIVITIES PROGRAM.  01. Organized Program. There shall be an organized and supervised activity program appropriate to the needs and interests of each patient/resident. The program shall be designed to include a variety of processes and services which are designed to stimulate patients/residents to greater self-sufficiency, resumption of normal activities and maintenance of an optimal level of psychosocial functioning. It shall include recreation, therapeutic, leisure and religious activities. This Rule is not met as evidenced by: Refer to F248 regarding activities program issues.	C 674	C 674 Refer to response to F-248	
C 782	02.200,03,a,iv Reviewed and Revised	C 782	C 782 Refer to response to F-280	December 8, 2014 <i>dy</i>

Bureau of Facility Standards

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C 782	Continued From page 3  iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please see F 280 as it pertains to care plan revisions.	C 782		
C 784	02.200,03,b Resident Needs Identified  b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please see F 309 as it pertains to dementia care, and following resident care plans.	C 784	C 784 Refer to response to F-309	
C 785	02.200,03,b,i Grooming Needs  i. Good grooming and cleanliness of body, skin, nails, hair, eyes, ears, and face, including the removal or shaving of hair in accordance with patient/resident wishes or as necessitated to prevent infection; This Rule is not met as evidenced by: Refer to F312 as it relates to providing residents with showers/baths.	C 785	C 785 Refer to response to F-312	
C 787	02.200,03,b,iii Fluid/Nutritional Intake  iii. Adequate fluid and nutritional intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by:	C 787	C 787 Refer to response to F-327	8 December 1, 2014 <i>dy</i>

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001510	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/09/2014
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C 787	Continued From page 4  Refer to F327 as it relates to providing adequate fluids.	C 787		
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered  iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F328 as it relates to administering oxygen per Physician's orders.	C 788	C 788 Refer to response to F-328	
C 789	02.200,03,b,v Prevention of Decubitus  v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 as it relates to preventing pressure ulcers.	C 789	C 789 Refer to response to F-314	
C 790	02.200,03,b,vi Protection from Injury/Accidents  vi. Protection from accident or injury; This Rule is not met as evidenced by: Please see F 323 as it pertains to supervision to prevent incidents.	C 790	12/11/14 @ 2:15 PM PER ADMIN CHANGE TO C 790 Refer to response to <del>F328</del> F323	
C 795	02.200,03,b,xi Bowel/Bladder Evacuation/Retraining	C 795	C 795 Refer to response to F-315	8 December 1, 2014 <i>dy</i>

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>C</b> <b>10/09/2014</b>
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C 795	Continued From page 5  xi. Bowel and bladder evacuation and bowel and bladder retraining programs as indicated; This Rule is not met as evidenced by: Please see F 315 as it pertains to toileting plans.	C 795		
C 832	02.201,02,f Labeling of Medications/Containers  f. All medications shall be labeled with the original prescription legend including the name and address of the pharmacy, patient's/resident's name, physician's name, prescription number, original date and refill date, dosage unit, number of dosage units, and instructions for use and drug name. (Exception: See Unit Dose System.)  This Rule is not met as evidenced by: Refer to F431 as it relates to dosage information on medication labels.	C 832	C 832 Refer to response to F-431	
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: Refer to F514 as it relates to complete documentation on medical records.	C 881	C 881 Refer to response to F-514	December 8, 2014 <i>dy</i>



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

November 21, 2014

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

Provider #: 135067

FILE COPY

Dear Ms. Berg:

On **October 9, 2014**, a Complaint Investigation survey was conducted at Good Samaritan Society - Moscow Village. Nina Sanderson, L.S.W., Bradley Perry, L.S.W. and Lauren Hoad, R.N. conducted the complaint investigation.

During the investigation, the following items were reviewed for all allegations in this complaint:

- The survey was initiated on a Sunday afternoon, with observations continuing until Thursday;
- Call light response time reports;
- Facility's staffing records for three-weeks prior to the survey as well as the week of survey;
- Interviews with residents, residents' family members and staff;
- A Resident Group Interview was conducted;
- Sixteen residents' records were reviewed, including bathing records.

The complaint allegations, findings and conclusions are as follows:

**Complaint #6660**

**ALLEGATION #1:**

The complainant stated the facility was "short-staffed" on the weekends, with residents either waiting for an extended period for assistance or going without assistance.

**FINDINGS #1:**

The staff present when the survey team entered the facility on Sunday afternoon stated there was not enough staff to meet residents' needs. This was confirmed through interviews with residents,

residents' family members and the facility's management.

This portion of the complaint was cited at F309, F318, F323 and F353.

**CONCLUSIONS:**

Substantiated. Federal and State deficiencies related to the allegation are cited.

**ALLEGATION #2:**

The complainant stated an identified resident was left in soiled incontinence briefs for extended periods. The complainant also reported other residents in the facility were not being assisted to the toilet timely.

**FINDINGS #2:**

The identified resident was no longer residing in the facility at the time the survey was conducted. The resident's record was reviewed, but there was insufficient evidence to ascertain whether the resident had been left soiled. However, the survey team found other residents who lacked care plans to address incontinence. This portion of the complaint was substantiated for other residents and cited at F315.

**CONCLUSIONS:**

Substantiated. Federal and State deficiencies related to the allegation are cited.

**ALLEGATION #3:**

The complainant stated an identified resident developed open areas on his/her buttocks from being left in soiled incontinence briefs.

**FINDINGS #3:**

The identified resident was no longer residing in the facility at the time the survey was conducted. His/her record was reviewed. There were documented issues with his/her buttocks, although the physician had identified another cause for these issues. However, the survey team identified other residents who developed open areas while in the facility. This portion of the complaint was cited at F314.

**CONCLUSIONS:**

Substantiated. Federal and State deficiencies related to the allegation are cited.

**ALLEGATION #4:**

The complainant stated showers were not being done in the facility. No specific residents were identified.

Jamie M. Berg, Administrator  
November 21, 2014  
Page 3 of 3

FINDINGS #4:

The survey team identified sample residents who were not receiving consistent showers or baths. This portion of the complaint was cited at F312.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #5:

The complainant stated an identified resident was discharged from the facility to an acute care hospital and was found to have bruising upon arrival to the hospital. The complainant did not report where on the resident's body the bruises were located.

FINDINGS #5:

The identified resident's record was reviewed. The facility had been performing regular skin checks on the identified resident, which included a skin check the day the resident discharged from the facility. There was no bruising noted on any of the skin checks.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor  
Long Term Care

LKK/dmj