IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7012 3050 0001 2128 2569

January 9, 2014

Susan Jones, Administrator
Good Samaritan Society-- Idaho Falls Village
840 East Elva Street
Idaho Falls, ID 83401-2899

Provider #: 135092

Dear Ms. Jones:

On **December 20, 2013**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Good Samaritan Society-- Idaho Falls Village by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE**: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date, to signify when you allege that each tag will be back in compliance**. WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. After each deficiency has been answered and dated, the administrator should sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in

the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **January 22, 2014**. Failure to submit an acceptable PoC by **January 22, 2014**, may result in the imposition of civil monetary penalties by **February 11, 2014**.

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

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

- What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:

  a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.

  b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.

  c. Start date of the audits;

- Include dates when corrective action will be completed in column 5.

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

- The administrator must sign and date the first page of both the federal survey report, Form

CMS-2567 and the state licensure survey report, State Form.

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 **January 24, 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 **January 24, 2014**. A change in the seriousness of the deficiencies on **January 24, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 24, 2014** includes the following:

Denial of payment for new admissions effective **March 20, 2014**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 20, 2014**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS

Regional Office or the State Medicaid Agency beginning on **December 20, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

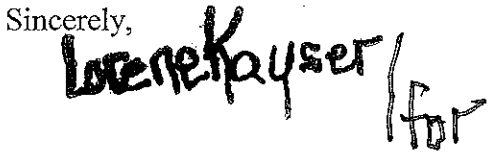
- BFS Letters (06/30/11)

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

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

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

Sincerely,



LORETTA TODD, RN, Supervisor
Long Term Care

LT/lj
Enclosures

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

PRINTED: 01/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135092		C 12/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE	840 EAST ELVA STREET IDAHO FALLS, ID 83401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual federal recertification and complaint survey of your facility. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Lauren Hoard, RN, BSN Sherri Case, LSW, QMRP The survey team entered the facility on 12/16/13 and exited on 12/20/13 Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CM= Case Manager CNA = Certified Nurse Aide DNS = Director of Nursing Services LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment MG = Milligrams POA = Power of Attorney PRN = As Needed	F 000	This plan of correction is submitted as required under state and federal law. The submission of this Plan of correction does not constitute an admission on the part of Good Samaritan Society – Idaho Falls Village as to the accuracy of the surveyors' findings nor the conclusions drawn there from. The Facility's submission of this Plan of Correction does not constitute an admission on the part of the Facility that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied. This Plan of Correction is not to be used as evidence against the Facility in any action in any court or Administrative hearing. RECEIVED JAN 22 2014 FACILITY STANDARDS	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.	F 167		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	1/26/2014

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

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F 167	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure the results of the most recent survey were readily accessible to residents. This deficient practice was true for any resident or their representative who may want to review the survey results, including 13 of 13 sample residents (#1 - 13). Findings included: On 12/16/13 at 3:35 PM, a Survey Results binder was located on a table in the facility entrance foyer. Inside the binder was the last annual recertification survey dated 12/14/12. The results of the last complaint survey on 9/4/13 were not located in the binder. On 12/16/13 at 3:42 PM, the Administrator was asked about the missing survey results. The Administrator stated, "I just haven't gotten a copy in there yet...I will get them in." On 12/16/13 at 3:50 PM, the Administrator showed the surveyor she placed the missing survey in the binder and replaced the binder on the table. On 12/17/13 at 5:00 PM, the Administrator, DNS, and Social Services were informed of the surveyor's findings. No further information was provided.	F 167	Please accept the following plan of correction as our credible allegation of compliance for F-167: 1. Most current survey results were placed in binder outside of the Administrator's office at the time the recertification survey was taking place. 2. All residents who wish to view the current survey have the potential to be affected. 3. Administrative staff or designee will place most recent survey in resident/family access binder. Administrative staff was educated on 12/23/2013 to this process. 4. Beginning 1/20/2014, Director of Nursing or designee will audit to ensure most recent survey results are accessible/available for inspection by residents. Audit will be completed Q month x 12 months. All audit results will be reported to QA/CQI for further monitoring and recommendation. 5. Compliance will be achieved on or before 2/12/2014.	2/12/2014
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a	F 241		

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F 241	Continued From page 2 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 staff interview and observation, it was determined the facility failed to ensure residents were treated with dignity and respect during their dining experience when staff placed clothing protectors on residents and a resident was given a medication in the dining room after the meal had begun. This was true for 3 of 13 sampled residents (#s 1, 4, & 11), and 5 random residents (#s 16-20). This practice created the potential to negatively affect the residents' self-worth and self-esteem. Findings included: 1. On 12/17/13 at 12:25 PM during the lunch observation in the Helping Hands unit, Resident #s 4, 11, and 17-20 were observed to have clothing protectors on. On 12/18/13 at 5:00 PM during the dinner observation in the Helping Hands unit, CNA #1 was observed placing clothing protectors on Resident #s 4, 11, and 18-20, without asking permission. Each resident also had a cloth napkin as part of their table setting. On 12/19/13 at 7:50 AM during the breakfast observation in the Helping Hands unit, LPN #2 directed CNA #3 to start passing out the clothing protectors. CNA #3 asked Resident #s 4, 18, and 20 if they wanted clothing protectors, the residents responded in the affirmative and then she placed them on the residents. CNA #3 did not ask if they would like a cloth napkin instead,	F 241	Please accept the following plan of correction as our credible allegation of compliance for F-241: 1. Resident's #1, 4, 11, and 17-20, residents were not interviewable secondary to cognitive impairment. LSW will discuss with family or POA the elimination of clothing protectors; cloth napkins will replace the clothing protectors. Resident # 16 was interviewed and gave verbal consent to have medications administered in the dining room; care plan was amended. 2. All residents who have the desire to protect their clothing during mealtimes, or have medications administered at mealtimes have the potential to be affected by these practices. 3. Staff will be educated to provide care consistent with resident's preferences for (a) us of clothing protectors or cloth or paper napkins, (b) medications offered to residents in the dining room. Care plans reflect the resident's identified preferences. Staff will be educated at meetings on 1/16/2014 and 1/17/2014 on changes to these procedures.	

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F 241	Continued From page 3 which were placed at each residents table setting. Similar findings were found for Resident #1. On 12/19/13 at 11:53 AM, the DNS was interviewed regarding the clothing protectors. She stated, "Obviously we need to do some more training." 2. Random Resident #16 was admitted to the facility on 9/11/08 with multiple diagnoses which included constipation. Resident #16's Medication Review Report (physician recapitulation orders) for December 2013 documented in part: * "Senna-S tablet 8.6-50 MG Give 2 tablet by mouth three times a day." Resident #16's December 2013 Medication Record documented in part: * "Senna-S tablet 8.6-50 MG Give 2 tablet by mouth three times a day" at the Hours of 8:00 a.m., 12:00 p.m., and 6:00 p.m. On 12/18/13 at 5:34 p.m., during the dinner meal observation in the main dining room, LN #9 was observed taking a medication cup and a cup of water to Resident #16 after the meal had been served. The LN was asked what medications had been administered and she stated, "Senna." When asked if the resident was care planned to receive medications in the dining room, LN #9 responded, "Yeah." At 5:38 p.m. the surveyor received Resident #16's care plan for review. However, the care plan did not provide any instructions to staff that the resident preferred or had requested to receive medications in the dining room.	F 241	4. Beginning 1/20/2014, QA coordinator or designee will audit to assure that resident's care planned preferences for protection of clothing and medication administration in the dining room are Care Planned and honored. Audits will be completed q week x 4, q 2 weeks x 4, q month x 3, and quarterly x 2. All audit results will be reported to QA/CQI for further monitoring and recommendation. 5. Compliance will be achieved on or before 2/12/2014.	2/12/2014

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F 241	Continued From page 4	F 241		
	On 12/18/13 the Medication Record documented a check mark for the hour of 6:00 p.m. which indicated the medication had been administered to Resident #16.			
	On 12/19/13 at 2:12 p.m., the DNS was asked what the policy was for passing medications in the dining room. The DNS said there were some residents who had medications requested, and it would be on the resident's care plan.			
	On 12/9/13 at 4:40 p.m., the Administrator, DNS, Social Services, and Case Managers were informed of the medication administration issue in the dining room. However, no further information or documentation was provided.			
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246		
	A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.			
	This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, resident group meeting, staff interview and record review the facility failed to meet the needs of 2 of 13 residents sampled (#s 5 & 8), and 3 of 8 residents attending the group meeting, for accommodation of needs. Additionally 1 of 13 sampled residents (#12) was not bathed twice a			

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F 246	Continued From page 5 week as was her preference. The deficient practice had the potential to cause more than minimal harm when resident's call lights were not answered in a timely manner or when Resident #12's request to be bathed on a different day was not honored. Findings included: 1. During the meeting with the residents, on 12/17/13 at 1:20 p.m., 3 of 8 residents in attendance stated "Once in awhile" they had to wait 30 minutes for their call light to be answered. Two of 8 residents stated they had to wait 20 minutes for their call light to be answered "pretty often." When asked what pretty often meant they stated more than 1 time a week. The residents also stated early in the morning was when they had to wait longer. a. During an observation on 12/19/13 at 6:51 a.m. a call light was observed to be sounding for more than 20 minutes for Resident 23's room. The dashboard on the phone confirmed the alarm had been sounding for 26 minutes and 25 seconds. A call light audit from 12/1/13 to 12/19/13 for Resident 23's room, documented call light wait times for 6 out of 19 days (7 incidents), ranged from 18 minutes and 15 seconds to 28 minutes and 2 seconds. b. A resident from the group meeting call light audit was reviewed. The audit documented from 12/1/13 to 12/19/13 call wait times for 6 of 19 days (6 incidents) ranged from 24 minutes and 2 seconds to 35 minutes and 30 seconds. 2. Resident #8 was admitted to the facility on 6/10/11 and readmitted on 5/25/12 with diagnoses which included insomnia, generalized pain,	F 246	Please accept the following plan of correction as our credible allegation of compliance for F-246: 1. Regarding resident's #5 and 8 their call lights will be answered as soon as possible. Resident #5 reports post interview 10 minutes as reasonable response time, and resident # 8 reports 30 minutes as reasonable response time. In regards to resident # 12, they were interviewed by the LSW and chose a different day to bathe that didn't conflict with any other activities in their schedule. 2. All residents who have call lights and are bathed have the potential to be affected. 3. Staff will be educated to answer call lights in a timely manner and LSW or designee will discuss with resident their preferred day(s) and frequency for bathing. Staff will be educated at meetings on 1/16/2014 and 1/17/2014 (sign-in sheet available upon request). 4. Beginning 1/20/2014, QA coordinator or designee will audit to assure that call lights are being answered in a timely manner, and that residents are allowed to choose the days of the week that they are to receive their baths. Audits will be completed q week x 4, q 2 weeks x 4, q month x 3, and quarterly x 2. All audit results will be reported to QA/CQI for further monitoring and recommendation.	

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F 246	Continued From page 6 anxiety state and depressive disorder. The resident's 10/29/13 quarterly MDS assessment documented she was cognitively in tact. During an interview, on 12/17/13 at 9:50 a.m.,the resident stated the call light was not answered and she was left on the toilet for 1 hour. The resident also stated the aides will come in turn the call light off and state they will come back, but they do not come back. A call light audit from 12/1/13 to 12/19/13 for Resident #8's room documented call light wait times for 7 out of 19 days (12 incidents), ranged from 16 minutes and 27 seconds to 29 minutes and 10 seconds. On 12/19/13 at 10:04 a.m., LN #6 was asked how staff know when a call light is alarming and which room it belongs to. The LN stated they could, "Hear it. [They] also look at the dashboard" to see who's light was going off the longest. 3. Resident #12 was admitted to the facility on 8/11/10 with diagnoses which included insomnia and shortness of breath. On 12/16/13 at 2:50 p.m. the resident stated she was scheduled for two baths a week but only gets a bath on Saturdays. The resident stated the other scheduled day was Wednesday and she would miss "Bible Study" if she were to be bathed on Wednesday. The resident stated she really did need to be bathed more often as she had a rash under her breasts and in her peri-area but she did not want to miss the Bible study. When asked if she had informed the facility she would prefer her	F 246	5. Compliance will be achieved on or before 2/12/2014.	2/12/2014

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F 246	Continued From page 7 bath on another day the resident stated she had. The bath schedule provided by the facility documented the resident was to be bathed on days on Wednesday and Saturdays. The resident's 11/14/13 ADL Care Plan included in the intervention section the resident required 1 staff to assist with bathing. The Care Plan did not identify how often the resident was to be bathed. The Bathing report for 11/13 through 12/18/13 documented the resident had refused showers in November on Wednesdays 3 of 4 Wednesdays and had refused 3 of 3 showers on Wednesdays between 12/4/13 and 12/18/13. On 12/19/13 at 3:16 p.m.. the DON was informed of the above concern. The DON stated, "I ' m going to look into that. I was not aware of that. " She also said, " I recall something where she (the resident) had actually spoke with Melissa Sparks " about not wanting more than 1 shower per week. " It ' s been a while. " The facility provided no further documentation. 4. Resident #5 was admitted to the facility on 12/20/11 with multiple diagnoses including congestive heart failure and anxiety. The resident's annual MDS assessment dated 12/4/13, documented the resident required two person extensive assistance for transfers and dressing, was incontinent of bowel and bladder, and cognitively intact. On 12/17/13 at 9:43 AM the resident was	F 246		

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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
F 246	Continued From page 8 interviewed regarding call light time responses. The resident said she often waited for long periods of time after turning on her call light and stated, "They just say we will try to get someone to help you, but they don't come back." When asked to clarify this statement she said the staff will sometimes come in and turn off the call light and leave without assisting the resident, then when no one comes back after a few minutes, the resident turns on the call light again. The resident said the call light situation has upset her so much she has cried about it on a few occasions and stated, "We don't have enough help." She also said she had a wet incontinent brief on at that moment because no one had been in to check her brief since 5:00 AM that morning. On 12/19/13 a call light audit from 12/1/13 to 12/19/13 for Resident #5's room was requested and reviewed. Call light wait times for 7 out of 19 days, ranged from 17 minutes and 22 seconds to 37 minutes and 9 seconds. In addition, on 12/4/13 at 18:01 (6:01 PM) a call was placed by the resident and waited 17 minutes and 22 seconds before the call light was turned off. Five minutes later at 18:23 (6:23 PM) the resident turned on her call light again and waited 8 minutes and 19 seconds before the call light was turned off. On 12/7/13 at 12:07 PM a call was placed by the resident and waited 8 minutes and 18 seconds before the call light was turned off. Four minutes later at 12:19 PM another call was placed by the resident and waited 20 minutes and 55 seconds before the call light was turned off. Eight minutes later at 12:47 PM a call was placed by the resident and waited 2 minutes and 33 seconds	F 246		

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F 246	Continued From page 9 before the call light was turned off. On 12/19/13 at 2:50 PM, the DNS was interviewed regarding the call light issue. She was shown the call light data and she stated, "I'm taking notes so I can look into it a little bit more." On 12/19/13 at 4:35 PM, the Administrator, DNS, Social Services, and Care Manager were informed of the issues. No further information was provided. Refer to F353 for additional information regarding call lights not being answered timely.	F 246		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status;	F 272		

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F 272	Continued From page 10 Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure side rails used for 3 of 4 (#s 4-6) sampled residents reviewed for side rails were assessed for safety. This had the potential to harm the residents due to the risk of limb entrapment in the side rails. Findings included: 1. Resident #4 was admitted to the facility on 2/22/13 with multiple diagnoses including Alzheimers disease and esophageal reflux. On 12/16/13 at about 4:40 PM and throughout the survey process, bed cane side rails on both sides of the resident's bed were observed in the upright position. The resident's care plan identified an approach for the problem area for Falls. One of the interventions on 11/20/13 was bilateral bars (side	F 272	Please accept the following plan of correction as our credible allegation of compliance for F-272: 1. Resident #4, 5, and 6 have been assessed for side rail safety and results documented in the IDP notes. Care Plans have been updated and will be reviewed quarterly, and with any significant change. 2. All residents with the need for side rails have the potential to be affected. 3. Licensed nursing staff will be in-serviced to assess side rails for safety and provide documentation statement at the appropriate intervals on 1/16/2014 and 1/17/2014. 4. Beginning 1/20/2014, QA coordinator or designee will audit to assure that all residents with side rails or assist bars will receive proper assessment with documentation regarding safety. Audits will be completed q week x 4, q 2 weeks x 4, q month x 3, and quarterly x 2. All audit results will be reported to QA/CQI for further monitoring and recommendation. 5. Compliance will be achieved on or before 2/12/2014.	2/12/2014

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F 272	Continued From page 11 rails) for positioning. The resident's Physical Restraint Assessment and Evaluation, dated 11/16/13, did not include an assessment for side rail safety. 2. Resident #5 was admitted to the facility on 12/20/11 with multiple diagnoses including congestive heart failure and anxiety. On 12/17/13 at 8:15 AM and throughout the survey process, full side rails on both sides of the resident's bed were observed in the upright position. The resident's care plan identified an approach for the problem area for ADL self care. One of the interventions on 12/9/13 was, "Resident is able to: help turn side to side with bed rails." The resident's Physical Restraint Assessment and Evaluation, dated 12/9/13, did not include an assessment for side rail safety. 3. Resident #6 was admitted to the facility on 5/24/12 with multiple diagnoses including muscle weakness, psychosis and depression. On 12/16/13 at 4:45 PM and throughout the survey process, bed cane side rails on both sides of the resident's bed were observed in the upright position. The resident's care plan identified an approach for the problem area for ADL self care. One of the interventions on 11/15/13 was, "Resident is able to: use assist bars to turn in bed." The resident's Physical Restraint Assessment	F 272		

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F 272	Continued From page 12 and Evaluation, dated 11/12/13, did not include an assessment for side rail safety. On 12/19/13 at 2:14 PM CM #4 was interviewed regarding side rail assessments. She stated, "I have always done them to identify if they are a restraint." On 12/19/13 at 4:35 PM, the Administrator, DNS, Social Services, and Care Manager were informed of the issues. No further information was provided.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. 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. This REQUIREMENT is not met as evidenced	F 280		

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F 280	Continued From page 13 by: Based on observation, record review, and staff interview it was determined the facility failed to update and/or revise residents' care plans after there were changes in the residents' status. This was true for 3 of 13 sample residents (#s1, 4 and 7). This failure created the potential for harm if staff were confused about directions for: * Depression and suicidal statement management for Resident #1; * Refusals of care for Resident #7; and, * After meal interventions for Resident #4. Findings included: 1. Resident #1 was admitted to the facility on 10/16/87 and readmitted on 11/27/13 with multiple diagnoses which included multiple sclerosis (MS) and expressive aphasia. The Care Plan for Resident #1, dated 11/7/13, documented in part: * Focus - "The resident has a mood problem R/T (related to) depression E/B (evidenced by) occasional tearfulness and hx (history) of suicidal statements;" * Interventions - "Monitor/record/report to health care provider PRN risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note, etc.), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med[ications] or therapies, sense of hopelessness or helplessness, impaired judgement or safety awareness;" * Focus - "Resident has a communication problem R/T expressive aphasia E/B seldom able to verbalize to make needs known;" * Interventions - "Ask yes/no questions, to help	F 280	Please accept the following plan of correction as our credible allegation of compliance for F-280: 1. Resident #1 has been re-evaluated for depression and suicidal statements. Care plan had been amended to clarify care directions/actions in the event of further depression symptoms or suicidal statements. Resident #7 has been interviewed for bathing preferences and Care plan updated to include interventions for bathing refusals. Resident #4 was re-evaluated for post-meal interventions related to GERD diagnosis. Care Plan has been modified to reflect individualized interventions. 2. All residents have the potential to be affected. 3. Staff (Nursing, social services, Activities, and Dietary) will be re-educated to notify the Case Managers of discrepancies in care plan interventions. Staff will be in-services on changes to this procedure on 1/16/2014 and 1/17/2014.	

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F 280	Continued From page 14 resident verbally add to activity. Praise all response efforts." On 12/18/13 at 21:31 p.m., the CM #4 and CM #8 were asked if Resident #1 had a diagnosis of depression. CM #4 looked at the computer and stated, "She doesn't." CM #8 added, "She's a happy person." When asked if the resident made suicidal statements, CM #4 stated, "She hasn't," and added the interdisciplinary team updated the care plans but,"Not doing it as much yet. They'll get more training how and when to update." On 12/19/13 at 11:20 a.m., CM #4 provided an Interdisciplinary Progress Note that documented in part: * 10/13/10 - "(late entry 10/12/10) While conducting interview for MDS, Res[ident] stated that she had had thoughts of hurting herself or that she would be better off dead. Res[ident] was started on 15 min[ute] checks. Will continue to monitor." Note: The resident's care plan did document a history of suicidal statements. However, the resident was no longer able to make such statements due to aphasia. 2. Resident #7 was admitted to the facility on 1/14/13 and readmitted on 5/24/13 with multiple diagnoses which included depressive disorder and generalized pain. The Care Plan for Resident #7, dated 10/30/13 and revised on 11/19/13, documented in part: * Focus - "The resident has an ADL self care performance deficit R/T weakness, limited mobility E/B requires staff assistance to complete ADL's;" * Interventions - "BATHING: Resident requires	F 280	4. Beginning 1/20/2014, Case Manager or designee will audit residents with depression and suicidal statements to assure that interventions are applicable and appropriate. Residents with refusal of care are investigated and Care Plans changed as needed, Residents with a diagnosis of GERD have best practice interventions in plan of care and they are being followed. Audits will be completed q week x 4, q 2 weeks x 4, q month x 3, and quarterly x 2. All audit results will be reported to QA/CQI for further monitoring and recommendation. 5. Compliance will be achieved on or before 2/12/2014.	2/12/2014

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F 280	Continued From page 15 one staff participation with bathing." Resident #7's Bathing Report for November 2013 documented in part: * 11/06/13, Day shift, Refused (offered twice); * 11/13/13, Day shift, Refused; * 11/26/13, Evening shift, Refused (offered twice); * 11/29/13, Evening shift, Refused; and, * 12/3/13, Evening shift, Refused (offered twice). On 12/19/13 at 2:40 p.m., CM #4 was interviewed about the resident's frequent refusal of showers and/or baths. When asked if the care plan instructed staff what to do when the resident refused showers, the CM stated, "I can add it in." CM #4 added the following to Resident #7's care plan: * "Bathing: provide resident with a sponge bath when a full bath or shower cannot be tolerated." 3. Resident #4 was admitted to the facility on 2/22/13 with multiple diagnoses including Alzheimer's disease and esophageal reflux. The resident's care plan documented on 11/20/13: -Focus area, "The resident has GERD (Gastroesophageal Reflux Disease) R/T (related to) metabolic, nausea and vomiting E/B (exhibited by) requires therapeutic medication regimen." -Goal, "The resident will remain free from discomfort, complications or s/s (signs and symptoms) related to diagnosis of GERD through review date." -Interventions, "Avoid lying down for at least 1 hour after eating. Keep head of bed elevated. Encourage to stand/sit upright after meals." -Focus area, "The resident has an ADL self care performance deficit R/T dementia E/B requires	F 280		

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F 280	Continued From page 16 assistance to complete ADL's" -Intervention, "Transfer [Resident #4] to bed to rest as she desires after meals." On 12/17/13 at 8:28 AM, Resident #4 was observed eating breakfast in the dining room. At 9:17 AM (49 minutes later) the resident was observed lying down in bed with her head elevated. At 12:37 PM the resident was observed in the dining room eating lunch. At 1:00 PM (23 minutes later) an aide was observed lying the resident down in bed with the resident's head elevated. On 12/18/13 at 1:40 PM, CM #4 was interviewed regarding the resident's care plan. She said the resident usually requests to lay down after meals. When asked why does to care plan appear to contradict itself regarding after meal interventions, the CM stated, "I see what you are saying." On 12/19/13 at 4:35 PM, the Administrator, DNS, Social Services, and Care Manager were informed of the issues. No further information was provided.	F 280		
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.	F 309		

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F 309	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure physician orders were followed and care plan interventions were implemented. This was true for 1 of 13 (#1) sampled residents. This practice created the potential for harm related to cares not provided as ordered, interventions for increased nutrition not provided per the care plan, and pain assessments not performed for Resident #1. Findings included: 1. Resident #1 was admitted to the facility on 10/16/87 and readmitted on 11/27/13 with multiple diagnoses which included multiple sclerosis, hypertension, and femur fracture. Resident #1's most recent quarterly MDS assessment, dated 8/5/13, documented in part: * Severely impaired cognition with a BIMS score of 4; * Poor appetite or overeating, several days in frequency; * Extensive assistance with 2 or more people for bed mobility; * Total dependent with 2 or more people for transfers, dressing, and toilet use; * Extensive assistance with 1 person for eating; * Total dependent with 1 person for personal hygiene and bathing; * On scheduled pain medication regimen; and, * Received non-medication interventions for pain. a. The Care Plan for Resident #1, dated 10/29/13, documented in part: * Focus - "The resident has hypertension R/T (related to) chronic HTN (hypertension) E/B (evidenced by) medication and monitoring	F 309	Please accept the following plan of correction as our credible allegation of compliance for F-309: 1. Resident #1 will have care plan interventions followed to (a) assure blood pressure will be checked prior to administering medication and licensed nurse will verify if within range for administration, per MD order, with correct documentation to follow. Care plan interventions will be followed regarding (b) off-loading of pressure – resident's time in the chair will be limited per the care plan intervention, including interventions for LN if resident is not compliant with interventions, and (c) care plan approaches for pain management will be followed and documented per the individualized interventions, and (d) care plan approaches for resident specific snack/food interventions will be followed. Order for 120 ml cranberry juice, one time a day, clarified and treatment sheet updated to capture administration. Physician food orders will be documented on point of care documentation. 2. All resident have the potential to be affected by this practice. 3. Licensed nursing staff will be in-serviced on the changes to these procedures on 1/16/2014 and 1/17/2014.	

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F 309	Continued From page 18 required;" * Interventions - "Monitor/document/report to health care provider PRN any s/s (signs/symptoms) of malignant hypertension;" The Medication Review Report (physician recapitulation orders) for December 2013 documented in part: * Clonidine HCl Tablet 0.1 MG by mouth two times a day related to unspecified essential hypertension. Do not give if systolic blood pressure is [less than] 140. Resident #1's Medication Record for December 2013 documented in part: "CloNIDine HCl Tablet 0.1 MG Give 0.1 MG by mouth two times a day related to unspecified essential hypertension. Do not give if systolic BP (blood pressure) is [less than] 140." There are two boxes stacked vertically on the Medication Record. The box on top is for the blood pressure numbers. The bottom box holds a check mark which indicates the medication is administered. On 3 days in December the medication was marked as administered when the systolic blood pressure was less than 140 as follows: * 12/4/13 - BP 132/82, medication was administered; * 12/11/13 - BP 125/75, medication was administered; * 12/13/13 - BP 126/68, medication was administered. On 12/18/13 at 12:37 p.m., CM #4 was asked if Resident #1's blood pressure should be checked twice per day because the medication is scheduled for twice per day and has blood pressure parameters. The CM stated, "Sounds like it" and looked it up on the computer. The CM	F 309	4. Beginning 1/20/2014, Case Manager or designee will audit to assure that Physician orders and care plan interventions are being followed, related to vital signs, pain assessment, snacks, and resident refusals. Audits will be completed q week x 4, q 2 weeks x 4, q month x 3, and quarterly x 2. All audit results will be reported to QA/CQI for further monitoring and recommendation. 5. Compliance will be achieved on or before 2/12/2014.	2/12/2014

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F 309	Continued From page 19 added, "Ok, yep. Definitely." CM #4 was informed of the medication being administered 3 times when the blood pressure was outside of the administration parameters. b. The Care Plan for Resident #1, dated 10/29/13, documented in part: * Focus - "The resident has 3 pressure ulcers, coccyx, left and right ischial r/t hx. (history) of ulcers, Immobility, Incontinence, Poor nutrition;" and, * Interventions - "TRANSFER [resident's name] to bed to offload from bony prominences between meals." A consultation report with physician orders for Resident #1, dated 12/10/13, documented in part: * Off-Loading: "Limit patient's time in chair to 30-45 minutes. Patient needs to spend the majority of her time in bed avoiding pressure on wounds." On 12/17/13 the following observations were made of Resident #1: * 8:13 a.m., the resident was not found in her room; * 10:11 a.m., again the resident was not in her room and the bed was made. The resident was found in the day room in a tilt back wheelchair next to a fireplace; * 12:18 p.m., the resident was in the day room in the tilt back wheelchair across the room from the fireplace; * 12:40 p.m., the resident was in the dining room in the tilt back wheelchair refusing bites of pureed food; * 1:06 p.m., the resident was in her room sitting in the tilt back wheelchair which was parked near the bed facing the television; and,	F 309		

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F 309	Continued From page 20 * 2:09 p.m., the resident was lying in bed resting. Note: Resident #1 was observed sitting in her wheelchair for over 4 hours. On 12/18/13 the following observations were made of Resident #1: * 9:11 a.m., the resident was near the day room in the tilt back wheelchair getting blood drawn; * 10:40 a.m., the resident was in the family room at a table in the tilt back wheelchair; and, * 11:58 a.m., the resident was in the dining room waiting for the lunch meal in the tilt back wheelchair. Note: Resident #1 was observed sitting in her wheelchair for over 2 hours. On 12/18/13 at 12:40 p.m., CM #4 was asked how long Resident #1 was to be up in the wheelchair. The CM stated, "The Physician makes that order/recommendation," but it was the resident's right to refuse it. When asked what the staff were to do when the resident refused to lay down, the CM said they were to provide education and let the nurse on the floor know who would then provide more education. The CM was asked to provide documentation of the resident's refusals and the education which was provided. On 12/19/13 at 2:33 p.m., CM #4 stated, "I don't have the documentation of education." Additionally, no documentation was provided which indicated the resident refused to be laid down. Note: Resident #1's Care Plan did not provide instruction to staff on what to do when the resident refused to lay down. c. The Care Plan for Resident #1, dated 10/29/13,	F 309		

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F 309	Continued From page 21 documented in part: * Focus - "The resident is on pain medication therapy R/T disease process, pressure ulcers E/B occasional c/o (complaints of) breakthrough pain;" * Interventions - "Review every shift for pain medication efficacy: Assess whether pain intensity is acceptable to [resident's name], no treatment regimen or change in regimen required; controlled adequately by therapeutic regimen, no treatment regimen or change in regimen required but continue to monitor closely; controlled when therapeutic regimen followed, but not always followed as ordered; therapeutic regimen followed, but pain control not adequate, changes required;" Resident #1's Medication Review Report (physician recapitulation orders) for December 2013 documented in part: * Hydrocodone-Acetaminophen Capsule 5-500 MG Give 1 tablet by mouth three times a day for pain related to generalized pain; * Hydrocodone-Acetaminophen capsule 5-500 MG Give 1 tablet by mouth every 6 hours as needed for pain related to generalized pain. A Care Plan Approaches Report for Resident #1 for December 2013 documented: * Instruction: Assess pain Q (every) shift, pain scale used for this resident. Document level; * Date: 12/02/2013 Shift: Night; and, * Date: 12/16/2013 Shift: Night. Note: There were no other documented dates or shifts on the report which indicated the care plan approach for pain assessment had been implemented. On 12/18/13 at 12:48 p.m., CM #4 was asked	F 309		

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F 309	Continued From page 22	F 309		

how often pain should be assessed and documented for Resident #1. The CM stated, "Every shift at least." The CM was informed of the lack of documentation for pain assessments and acknowledged the issue by nodding her head.

On 12/18/13 at 1:30 p.m., LN #9 was asked where the effectiveness of pain medication was documented. The LN said they go back to the resident and look but don't write it down and added, "Its not monitored on the thing [the computer] here [on the medication cart]." The LN continued by saying for PRN pain medication there was a place on the computer to chart the effectiveness, but for scheduled pain medication, "We're watching to see if we see any changes."

On 12/18/13 at 1:43 p.m., CM #4 was asked how the effectiveness of pain medication was documented. The CM said for PRN pain medication the LN's have a 30 minute window to monitor the effectiveness, and when the pain medications were scheduled, it was the pain assessment done every shift.

d. The Care Plan for Resident #1, dated 10/29/13, documented in part:
* Focus - "The resident has nutritional problem or potential nutritional problem E/B Hx of weightloss [no space added] and PEG (percutaneous endoscopic gastrostomy) tube;" and,
* Interventions - "Scheduled resident specific snack/food intervention #1 large chocolate milk and cranberry juice with each meal. Scheduled resident specific snack/food intervention #2 pudding with lunch and dinner. Yogurt with breakfast."

Resident #1's Medication Review Report

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F 309	Continued From page 23 (physician recapitulation orders) for December 2013 documented in part: * 120 ML cranberry juice one time a day for urinary tract health related to multiple sclerosis. Note: The Medication Record did not provide an area for the cranberry juice to be documented. Resident #1's Care Plan Approaches for December 2013 documented in part: * Instruction: Snack offered large chocolate milk and cranberry juice with each meal; * 12/01/2013, Day shift; * 12/05/2013, Evening shift; * 12/07/2013, Evening shift; * 12/09/2013, Evening shift; * Instruction: Pudding with lunch and dinner. Yogurt with breakfast; * 12/01/2013, Day shift; * 12/05/2013, Evening shift; * 12/07/2013, Evening shift; and, * 12/09/2013, Evening shift; Note: There were no other documented dates or shifts on the report which indicated the care plan approaches for chocolate milk, cranberry juice, pudding, and yogurt had been implemented. On 12/18/19 at 12:45 p.m., CM #4 was asked how often Resident #1 should be offered chocolate milk and cranberry juice. After looking over information on the computer the CM stated, "It says with each meal." The CM added that it would not be documented anywhere else but on the care plan approach flowsheets. CM #4 was asked how often the resident should have pudding and yogurt. After looking over the information on the computer the CM stated, "Ok" and nodded her head in acknowledgement of the documentation issue.	F 309		

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F 309	Continued From page 24 On 12/19/13 at 4:40 p.m., the Administrator, DNS, Social Services, and Case Managers were informed of the physician order and care plan issue. No further information or documentation was provided.	F 309	Please accept the following plan of correction as our credible allegation of compliance for F-312: 1. Residents #1 and #8, LSW has interviewed/ discussed with residents when they would like to take a shower/ bath and care plan has been updated to reflect these changes. Residents #2 and #13 have discharged. 2. All resident that need bathing assistance have the potential to be affected by this practice. 3. Nursing staff will be re-in-serviced to follow the residents care plan for frequency of bathing and steps to take if resident is refusing. Staff will be educated at meetings on 1/16/2014 and 1/17/2014. 4. Beginning 1/20/2014, Case Manager or designee will audit to assure that residents receive bathing per preferences and any refusals are addressed. Audits will be completed q week x 4, q 2 weeks x 4, q month x 3, and quarterly x 2. All audit results will be reported to QA/CQI for further monitoring and recommendation. 5. Compliance will be achieved on or before 2/12/2014.	2/12/2014
F 312 SS=E	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 record review, resident's attending the group meeting, resident and staff interview, it was determined the facility did not ensure residents received baths as needed and scheduled. This was true for 4 of 13 residents (#s 1-2, 8 and 13) sampled for ADL assistance. The deficient practice had the potential to cause more than minimal harm if residents experienced rashes or skin issues due to not being bathed regularly. Findings included: 1. During the group meeting with the residents, on 12/17/13 at 1:20 p.m. At least 2 of the residents stated there were not enough staff to ensure showers were given. One of the residents stated he/she did not receive baths as scheduled. The resident stated he/she "Has to push the issue to get a bath." Residents also reported they may be offered a bath but not until 8:00 - 9:00 p.m. which was too late.	F 312		

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F 312	Continued From page 25 2. Resident #2 was admitted to the facility on 8/3/13 with diagnoses which included pressure ulcers, fracture and incontinence. The resident's 11/2/13 Care Plan for ADL care documented in the intervention section she was to be bathed 1-2 times per week and as needed. Note: The care plan did not include if the resident refused baths to reapproach later or include how many baths were to be received each week. On 12/18/13 at 12:49 p.m.CM #4 stated, "The standard is twice a week and as needed. The resident's Bathing report for 10/13 documented she had been showered on 10/16/13, refused a shower on 10/19/13 and not offered another shower until 10/23/13 (7 days). The resident was not offered another shower until 10/30/13, which was refused. Resident #2 was not showered until 11/6/13 or or 14 days after the shower on 10/23/13. In November the resident received a shower on 11/27/13 and did not receive another shower until 12/4/13 (7 days). The bathing report did not document the resident had refused a shower between 11/27/13 and 12/4/13. The resident refused a shower on 12/11/13 but did receive a bed bath. The resident was not showered again until 12/14/13. The resident's medical record did not include any documentation as to why she refused bathing or the facility had discussed the refusals with the resident. On 12/19/13 at 4:40 p.m., the Administrator, DNS, Social Services, and Case Managers were informed of the bathing issue. However, no	F 312		

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F 312	Continued From page 26 further information or documentation was provided. 3. Resident #8 was admitted to the facility on 6/10/11 and readmitted on 5/25/12 with diagnoses which included insomnia, generalized pain, anxiety state and depressive disorder. The resident's 10/29/13 quarterly MDS assessment documented she was cognitively intact. The resident's 10/29/13 ADL Care Plan documented she required 1 staff to assist her to bath. The care plan did not include how often she was to be bathed, however the bathing schedule documented she was to be bathed 2 times a week on Tuesdays and Thursdays. On 12/17/13 at 9:50 a.m. Resident #8 stated she was to be showered 2 times a week. The resident stated that if the facility was "short on aides" she would not get a shower and had missed showers the month of November. The resident added it did bother her not to get a bath. Review of the Bathing Report documented the resident had a shower on 11/8/13 but not again until 11/15/13 (7 days). The resident was showered on 11/19/13 but not showered again until 11/26/13 (7 days). The Bathing Report did not document any refusals. 4. Resident #1 was admitted to the facility on 10/16/87 and readmitted on 11/27/13 with multiple diagnoses which included multiple sclerosis. Resident #1's most recent quarterly MDS	F 312		

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F 312	Continued From page 27 assessment, dated 8/5/13, documented in part: * Severely impaired cognition with a BIMS score of 4; * Extensive assistance with 2 or more people for bed mobility; * Total dependent with 2 or more people for transfers, dressing, and toilet use; and, * Total dependent with 1 person for personal hygiene and bathing. Resident #1's Care Plan, dated 10/29/13, documented in part: * Focus - "The resident has an ADL self care performance deficit R/T (related to) activity intolerance, limited mobility E/B (evidenced by) requires assistance to complete ADL's;" and, * Interventions - "BATHING: [Resident's name] is totally dependent on staff to provide a bath 2 x (times) weekly and as necessary with a bath board; BATHING: Provide resident with a sponge bath when a full bath or shower cannot be tolerated." A December 2013 Bathing Report for Resident #1 documented the date, shift, type of bath given, not available or refused, and user. The following information was documented: * 12/02/2013, Day, Shower; Note: Resident received only 1 shower for the week of 12/1/13. * 12/12/2013, Day, Shower; and, Note: Resident received only 1 shower for the week of 12/8/13. * 12/16/2013, Day Shower. Note: After 12/2/2013, 10 days passed without any documentation the resident received or refused a shower or bath. On 12/18/13 at 12:49 p.m., CM #4 was asked	F 312		

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F 312	Continued From page 28 why Resident #1 had only been bathed once during the weeks of 12/1/13 and 12/8/13. The CM stated, "The standard is twice a week and as needed. That's on her care plan too." The CM was asked if refusals should be charted at which she nodded her head yes. When asked what the staff were to do if the resident refused a shower or bath CM #8 responded, "Go back later and offer again." After reviewing the documentation on the computer, CM #4 stated, "I don't know what to say." On 12/18/13 at 1:48 p.m., CNA #11 was asked who performed showers. The CNA said whoever was on the assignments, generally 2 CNA's were scheduled for baths plus the usual resident care tasks. When asked what they were to do if a resident refused a shower or bath, the CNA stated, "Chart it, ask later on, have another CNA ask and encourage the best you can." CNA #11 added that they passed it on to the next shift if the resident had not agreed to shower by the end of their shift. On 12/18/13 at 5:05 p.m., CNA #12, was interviewed about showers. The CNA said showers were performed from 2:00 p.m. to 5:00 p.m. and after dinner if they had time, but most residents went straight to bed after dinner. When asked how many showers needed to be done on the evening shift, the CNA stated, "5 to 6." 5. Resident #13 was admitted to the facility on 11/1/13 with multiple diagnoses which included a knee replacement. Resident #13's PPS 30-Day scheduled MDS assessment, dated 11/17/13, documented in part: * Cognitively intact with BIMS score of 15;	F 312		

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F 312	Continued From page 29 * Extensive assistance needed with 2 or more people for bed mobility, transfers, walking and locomotion, and toilet use; * Limited assistance needed with the help of 1 person for personal hygiene; and, * Physical assistance needed with 1 person for bathing. Resident #13's Bathing Report for December 2013 documented the date, shift, type of bath given, not available or refused, and user. The following information was documented: * 12/06/2013, Day, Refused; * 12/06/2013, Day, Sponge bath; Note: Resident received only 1 shower/bath for the week of 12/1/13. * 12/13/2013, Day, Shower; and, Note: Resident received only 1 shower for the week of 12/8/13. * 12/16/2013, Day, Shower. Note: There was no documentation the resident had refused a shower on the weeks of 12/1/13 and 12/8/13. On 12/19/13 at 4:40 p.m., the Administrator, DNS, Social Services, and Case Managers were informed of the bathing issue. However, no further information or documentation was provided.	F 312		
F 314 SS=D	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	F 314		

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F 314	Continued From page 30 pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to provide the necessary nursing care and services to prevent pressure ulcers and treat existing pressure ulcers for 2 of 3 sampled residents (#s 1 and 2). This created the potential for more than minimal harm when the facility failed to implement preventative and treatment measures for Resident #1 and Resident #2. Findings included: 1. Resident #1 was admitted to the facility on 10/16/87 and readmitted on 11/27/13 with multiple diagnoses which included multiple sclerosis and pressure ulcers. Resident #1's most recent quarterly MDS assessment, dated 8/5/13, documented in part: * Severely impaired cognition with a BIMS score of 4; * Extensive assistance with 2 or more people for bed mobility; * Total dependent with 2 or more people for transfers, dressing, and toilet use; * Total dependent with 1 person for personal hygiene and bathing; * Risk of pressure ulcers; * 1 or more unhealed pressure ulcers at stage 1 or higher; * 1 stage 3 pressure ulcer; and, * 1 stage 4 pressure ulcer.	F 314	Please accept the following plan of correction as our credible allegation of compliance for F-314: 1. Resident #1 was reassessed for care needs related to pressure reduction. Care plan has been updated to reflect assessment findings and interventions when resident refuses. Resident/family education on physician recommendation has been documented. Resident #2 has discharged. 2. All resident with actual or potential pressure ulcers have the potential to be affected by this practice. 3. Nursing staff will be re-in-serviced to assure that residents receive instruction related to identified needs, and receive care and services to prevent and document treatment of existing pressure ulcers. Staff will be educated on documentation of education and compliance with assessments on 1/16/2014 and 1/17/2014. 4. Beginning 1/20/2014, Case Manager or designee will audit to assure care provided matches care planned and education has been provided to resident/family if refusals or deviations from plan of care occur. Audits will be completed q week x 4, q 2 weeks x 4, q month x 3, quarterly x2. All audit results will be reported to QA/CQI for further monitoring and recommendation.	

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F 314	Continued From page 31 The Care Plan for Resident #1, dated 10/29/13, documented in part: * Focus - "The resident has 3 pressure ulcers, coccyx, left and right ischial r/t hx. (history) of ulcers, Immobility, Incontinence, Poor nutrition;" and, * Interventions - "TRANSFER [resident's name] to bed to offload from bony prominences between meals;" * Focus - "The resident has an ADL self care performance deficit R/T (related to) activity intolerance, limited mobility E/B (evidenced by)requires assistance to complete ADL's;" and, * Interventions - "TRANSFER resident to bed to rest first down, last up between meals." A consultation report with physician orders for Resident #1, dated 12/10/13, documented in part: * Off-Loading: "Limit patient's time in chair to 30-45 minutes. Patient needs to spend the majority of her time in bed avoiding pressure on wounds." On 12/17/13 the following observations were made of Resident #1: * 8:13 a.m., the resident was not found in her room; * 10:11 a.m., again the resident was not in her room and the bed was made. The resident was found in the day room in a tilt back wheelchair next to a fireplace; * 12:18 p.m., the resident was in the day room in the tilt back wheelchair across the room from the fireplace; * 12:40 p.m., the resident was in the dining room in the tilt back wheelchair and refused bites of pureed food; * 1:06 p.m., the resident was in her room sitting in the tilt back wheelchair which was parked near	F 314	5. Compliance will be achieved on or before 2/12/2014.	2/12/2014

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GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE	840 EAST ELVA STREET IDAHO FALLS, ID 83401

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F 314	Continued From page 32 the bed facing the television; and, * 2:09 p.m., the resident was lying in bed resting. Note: Resident #1 was observed sitting in her wheelchair all morning after breakfast, and again after lunch. On 12/18/13 the following observations were made of Resident #1: * 9:11 a.m., the resident was near the day room in the tilt back wheelchair getting blood drawn; * 10:40 a.m., the resident was in the family room at a table in the tilt back wheelchair; and, * 11:58 a.m., the resident was in the dining room waiting for the lunch meal in the tilt back wheelchair. Note: Resident #1 was observed sitting in her wheelchair all morning after breakfast. On 12/18/13 at 12:35 p.m., CM #4 was asked how often Resident #1 was to be repositioned. The CM stated, "Every 2 hours. [The resident] chooses to stay up in the chair." The CM added ,"She stays up longer than I prefer" and said the resident was to be laid down after meals. On 12/18/13 at 12:40 p.m., CM #4 was asked how long Resident #1 was to be up in the wheelchair. The CM stated, "The Physician makes that order/recommendation," but it was the resident's right to refuse it. When asked what the staff were to do when the resident refused to lay down, the CM said they were to provide education and let the nurse on the floor know who would then provide more education. The CM was asked to provide documentation of the resident's refusals and the education which was provided. On 12/19/13 at 2:33 p.m., CM #4 stated, "I don't have the documentation of education."	F 314		

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F 314	Continued From page 33 Additionally, no documentation was provided which indicated the resident refused to be laid down. 2. Resident #2 was admitted to the facility on 8/3/13 with diagnoses which included pressure ulcers, dementia without behavioral disturbance and depressive disorder. An Interdisciplinary Progress Note (IPN) completed on 8/3/13 (date of admission) documented the resident was admitted with bilateral buttock and left heel suspected deep tissue injury. Wound Flow Sheets (WFS) for the left and right side of the coccyx for 8/7/13 through 10/28/13 did not consistently document length, width or depth, drainage or the surrounding skin condition. Additionally the wounds were not assessed from 8/10/13 until 8/26/13 (16 days) , 8/26/13 to 9/7/13 (12 days). During numerous observations from 12/16/13 through 12/19/13 the resident was observed to be wearing a plastic boot with a soft lining. The resident's 11/2/13 CP for pressure ulcers included an intervention to use a heel lift boot. On 12/18/13 at 2:00 p.m. the wound nurse was asked about the heel lift boot. She stated the care plan needed to be revised because the wound clinic had recommended a "Podus" boot. When asked about the lack of weekly documentation the wound nurse stated the previous nurse had failed to document consistently the size, and progress of the wounds.	F 314		

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F 315 F 315 SS=D	Continued From page 34 483.25(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 record review and resident and staff interview, the facility failed to ensure 2 of 8 (#5 & #1) sampled residents who were reviewed for incontinence care, received adequate incontinence care. This had the potential to harm the residents if they developed UTI's or experienced skin breakdown. Findings included: 1. Resident #5 was admitted to the facility on 12/20/11 with multiple diagnoses including congestive heart failure, retention of urine and anxiety. The resident's annual MDS assessment dated 12/4/13, documented the resident required two person extensive assistance for transfers and dressing, was incontinent of bowel and bladder, and cognitively intact. The resident's 12/9/13 bladder incontinence care plan documented an intervention, "Check every 2 hours and prn."	F 315 F 315	Please accept the following plan of correction as our credible allegation of compliance for F-315: 1. Resident #5 continence need was reassessed. Care plan updated to reflect individualized interventions. Resident #1 bowel continence need was reassessed and care plan updated to reflect individual bowel interventions. 2. All residents needing assistance with incontinence care have the potential to be affected by this practice. 3. Nursing staff providing consistent assignment cares were immediately re-educated on plan of care needs of these residents. Nursing staff will be in-serviced on 1/16/2014 and 1/17/2014; to changes in the procedure of incontinence assessment and individualized plan of care documentation. 4. Beginning 1/20/2014, Case Manager or designee will audit to assure that all residents with care plan interventions related to continence have appropriate documentation that those needs have been met. Audits will be completed q week x 4, q 2 weeks x 4, q month x 3, quarterly x2. All audit results will be reported to QA/CQI for further monitoring and recommendation. 5. Compliance will be achieved on or before 2/12/2014.	2/12/2014

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F 315	Continued From page 35 On 12/17/13 at 9:43 AM the resident was interviewed regarding how often she was checked and she said there were times like that day, she would go four or five hours before staff would check her. The resident's Care Plan Approaches was requested and reviewed on 12/18/13. The report documented instructions to, "Change Q[every] 2 H[ou]rs and PRN Ask resident is she needs checked and changed." There was no documentation for day shift for checking and changing on 12/10, 12/11, and 12/13/13. On 12/19/13 at 2:13 PM, CM#4 was interviewed regarding the care plan interventions. She was shown the dates in question and the surveyor said it appeared the resident was not checked and the CM stated, "I agree." 2. Resident #1 was admitted to the facility on 10/16/87 and readmitted on 11/27/13 with multiple diagnoses which included multiple sclerosis. Resident #1's most recent quarterly MDS assessment, dated 8/5/13, documented in part: * Severely impaired cognition with a BIMS score of 4; * Extensive assistance with 2 or more people for bed mobility; * Total dependent with 2 or more people for transfers, dressing, and toilet use; * Total dependent with 1 person for personal hygiene and bathing; * Indwelling catheter; and, * Always incontinent of bowel. The Care Plan for Resident #1, dated 10/29/13,	F 315		

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F 315	Continued From page 36	F 315		
	documented in part: * Focus - "The resident has bowel incontinence R/T (related to) limited mobility E/B (evidenced by) functional incontinence;" and, * Interventions - "Check resident every two hours and assist with brief change as needed." Resident #1's Care Plan Approaches Report for December 2013 documented instructions to, "Turn and reposition every 2 hours and PRN check and change." There was no documentation on day shift for checking and changing on 12/3/13 through 12/7/13, 12/9/13 through 12/13/13, nor on 12/15/13. There was no documentation on evening shift for checking and changing on 12/1/13 through 12/4/13, 12/6, 12/8, 12/10, and 12/12/13 through 12/16/13. There was no documentation on night shift for checking and changing on 12/1, 12/7, and 12/15/13. Note: There was no documentation at all for checking and changing on 12/15/13. On 12/18/13 at 12:40 p.m., CM #4 was asked how often charting should be completed for check and change for Resident #1. The CM stated, "At least once a shift" and added she would expect to see documentation at least 3 times per day. On 12/19/13 at 4:40 p.m., the Administrator, DNS, Social Services, and Case Managers were informed of the check and change issue. However, no further information or documentation was provided.			
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	F 328		

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F 328	Continued From page 37 special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure residents who use oxygen receive the liter flow as ordered by the physician, nor did the physician recapitulation orders include an order for oxygen even though a resident was receiving oxygen. This was true for 1 of 3 sampled residents (#1). This deficient practice created the potential for harm should a resident receive oxygen therapy at higher concentrations than ordered by the physician. Findings included: Resident #1 was admitted to the facility on 10/16/87 and readmitted on 11/27/13 with multiple diagnoses which included multiple sclerosis. The Care Plan for Resident #1, dated 10/20/13, documented in part: * Focus - "The resident has oxygen therapy R/T (related to) ineffective gas exchange;" and, * Interventions - "Monitor for s/s (signs and symptoms) of respiratory distress and report to health care provider PRN." Note: There was no physician's order for oxygen therapy for Resident #1.	F 328	Please accept the following plan of correction as our credible allegation of compliance for F-328: 1. Resident #1 oxygen needs were re-assessed and physician order was received for oxygen with liter flow identified. MAR updated. 2. All residents receiving oxygen or returning from the hospital have the potential to be affected by this practice. 3. Nursing staff will be re-educated, on 1/16/2014 and 1/17/2014, to ensure that resident receive care per physician orders. 4. Beginning 1/20/2014, Case Manager or designee will audit to verify physician orders are consistent with the cares being provided to the resident. Audits will be completed q week x 4, q 2 weeks x 4, q month x 3, quarterly x2. All audit results will be reported to QA/CQI for further monitoring and recommendation. 5. Compliance will be achieved on or before 2/12/2014.	2/12/2014

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F 328	Continued From page 38 On 12/17/13 at 12:23 p.m., Resident #1 was observed in the main dining room with no nasal cannula in place. The oxygen companion hanging on the wheelchair was turned to "0." A staff member was preparing the resident for the lunch meal. At 2:09 p.m., the resident was observed lying in bed with the nasal cannula in place. The oxygen concentrator was set at 2 LPM (liters per minute). On 12/18/13 at 9:11 a.m., Resident #1 was observed near the day room receiving a blood draw. The nasal cannula was in place and the oxygen companion on the wheelchair was set at 6 LPM. LN #10 was asked if the oxygen companion was set at 6 or 9 and she stated, "That's a 6" and turned the dial to the 5 and back to the 6 to verify. The LN then turned to assist the lab technician with the blood draw. On 12/18/13 at 11:58 a.m., Resident #1 was observed sitting in the main dining room for the lunch meal. The nasal cannula was in place and the oxygen companion on the wheelchair was at 2 LPM. LN #9 was interviewed about the oxygen administration rate for the resident. The LN said earlier that morning the resident had low oxygen saturations, therefore, she called the physician and received an order for oxygen at 2 LPM, titrate to 5 LPM to keep saturations to 90 percent. On 12/18/13 at 12:55 p.m., CM #4 was asked where the oxygen order was for Resident #1 at which she stated, "They told me this morning she doesn't have a current order." The CM said the resident did not have an order on admit but did prior to hospitalization. When asked if the CM saw an order for oxygen CM #4 responded,	F 328		

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F 328	Continued From page 39 "Nope. She does not have a current order." On 12/18/13 at 5:45 p.m., Resident #1 was not receiving any oxygen while in the main dining room for the dinner meal. On 12/19/13 at 4:40 p.m., the Administrator, DNS, Social Services, and Case Managers were informed of the oxygen therapy issue. However, no further information or documentation was provided.	F 328		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, it was determined the facility failed to ensure residents who received psychopharmacological medications: a. were managed and monitored, b. received gradual dose reductions (GDR), unless clinically contraindicated and c. failed to include nonpharmalogical interventions in care plans. These failures created the potential for harm should the medication regimen result in an unanticipated decline or newly emerging or worsening symptoms. This was true for 6 of 9 sample residents (#2, 3, 6, 7, 8 and 11). Findings included: 1. Resident #3 was admitted to the facility on 11/24/10 with diagnoses that included depressive disorder and unspecified psychosis. The resident's 11/27/13 quarterly MDS Assessment documented the resident had not had hallucinations or delusions, had a diagnosis of depression, had a psychiatric disorder other than schizophrenia and the resident received an antipsychotic medication. The resident's 12/13 Medication Review Report (Physician recapitulation orders) documented she was to receive Haloperidol (antipsychotic) 0.5 every day for Psychosis with Hallucination related to unspecified psychosis with a start date of 7/20/11.	F 329	Please accept the following plan of correction as our credible allegation of compliance for F-329: 1. Resident #3, Physician involved during GDR requested no changes due to clinical contraindications. Interventions have been customized to describe what hallucination symptoms were and non-pharmacological interventions to try if symptoms are displayed. Resident #2 was discharged on 12/19/2013. Resident #8 – depressive disorder signs, symptoms and non pharmacological interventions and pharmacy interventions were reassessed. Care plan has been updated to address individual symptoms /behaviors, documentation and non pharmacy interventions as well as MAR with pharmacy interventions per Physician order. Resident #6 – symptoms/behaviors have been assessed, psychoactive medication usage has be re-assessed, individualized behavioral monitoring for signs and symptoms have been set up and both non pharmacological and pharmacological intervention are care planned. GDR will be completed per protocol. Resident #11 has passed away. Resident #7 was	

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F 329	Continued From page 41 The resident's 12/13 medication administration record was requested on 12/17/13 and documented she had received the medication 12/1/13 through 12/17/13. The resident's 12/6/13 Care Plan identified the resident was on antipsychotic medication therapy for psychotic symptoms. The interventions section included to "monitor for symptoms of mania or psychosis (such as auditory, visual or other hallucinations/delusions." The interventions did not include information as to what the hallucinations were (such as loved ones, animals or voices etc.) or what nonpharmalogical interventions were to be tried if the symptoms were displayed. Documentation of the behaviors for 10/13 through 12/13 was requested from the Medical Records Supervisor (MRS). At 1:00 p.m. on 12/18/13 the MRS provided a Mood and Behavior Report (MBR) and a progress note written by the social worker. The MBR documented a behavior on 10/29/13 of "Rejection of Care." The progress note, dated 11/22/13 from the social worker, documented the resident was doing well and had one incident of rejecting care. On 12/18/13 at 1:30 p.m. the surveyor met with the social worker and asked if there was any other documentation regarding the hallucinations/delusions. The social worker stated the aides could document the behaviors in the computer, however there had not been any. The surveyor stated concern the Care Plan did not clarify what the hallucinations/delusions looked like. Additionally it was not clear if the behaviors had occurred and were not documented or if the antipsychotic was needed if the behaviors had not	F 329	reassessed by Behavioral Health Physician, and GDR determined to be appropriate. Medication was deceased. Documentation will continue to ensure resident capturing response to reduction attempt. Care plan has been individualized and updated to reflect non pharmacological interventions and effectiveness of behavior management. 2. All resident with psychopharmacological medications have the potential to be affected by this practice. 3. Social Services staff will be re-in serviced in assessment, identification and Care planning of non - pharmacy and pharmacy interventions for symptomology requiring individualized behavioral monitoring plans and Gradual dose reduction. Nursing staff will be re-educated to document behaviors with medication administration and ensure staff are offering/provide non-pharmacologic interventions including documenting of response to intervention. Staff will be in serviced on changes to procedures on 1/16/2014 and 1/17/2014 4. Beginning 1/20/2014, Case Manager or designee will audit to verify that staff is appropriately documenting non-pharmacological interventions, and that GDR and pharmacist follow-up occurs timely.	

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F 329	Continued From page 42 occurred. The surveyor then requested documentation that a gradual dose reduction had been discussed in the past year. The facility provided a 11/20/13 Behavioral Committee Drug Review. The form documented the target behavior of "Rejection of Care" and the use of the antipsychotic medication for psychosis with hallucinations. The form signed by the physician on 11/22/13 documented in the Attending Physician Comments "Stable -doing well." There was no further rationale for the continued use of the antipsychotic. Resident #3 continued on the antipsychotic medication even though there was no documentation the resident had hallucinations/delusions. The resident's only behavior was to resist care 1 time in 3 months, which does not justify the use of an antipsychotic medication. 2. Resident #2 was admitted to the facility on 8/3/13 with diagnoses which included dementia without behavioral disturbance and depressive disorder. A Physician order, dated 11/20/13, documented the resident was to receive Remeron (antidepressant) as, "As an appetite stimulant in the setting of depression." The resident's 12/13 MAR documented the resident had received the Remeron 12/1/13 though 12/17/13. The 12/1/13 MAR also documented the resident had received Celexa (antidepressant) 10 mg 12/1/13 through 12/17/13. The resident's 11/12/13 Care Plan (CP) for depression documented, "...mood problem	F 329	Audits will be completed q week x 4, q 2 weeks x 4, and q month x 3. All audit results will be reported to QA/CQI for further monitoring and recommendation. 5. Compliance will be achieved on or before 2/12/2014.	2/12/2014

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F 329	Continued From page 43 related to depression...preferring to stay in room and refusing cares." The CP intervention section included to observe for racing thoughts, increased irritability/frequent mood changes, flight of ideas, marked change in need for sleep, agitation or hyperactivity...loss of interest. Note: The CP did not clarify how racing thoughts, increased irritability, marked change in need for sleep or any of the identified behaviors would be identified. The intervention section included a non-pharmalogical intervention to "encourage activities." Documentation of the resident's behaviors for 10/13 through 12/17/13 were requested. The facility provided a Mood and Behavior Report which documented: 10/13 10/16/13 - Two incidents of trouble falling asleep or sleeping too much. The "Cause" for 1 stated "other" and the other one documented "Needs toileting" in the cause area. The "outcome" stated improvement on both incidents. Note: The monitor did not document if the resident was sleeping too much or having trouble falling asleep. 11/13 11/13/13 -Being short tempered, easily annoyed, behaviors not directed at others and unknown cause. The interventions were the resident was offered a snack and provided reassurance. The outcome stated no change.	F 329		

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F 329	Continued From page 44 Note: The CP did not identify an intervention of offering a snack. 12/13/ 12/6/13 - Being short tempered, easily annoyed, behaviors not directed at others and the cause was "other". The interventions were the resident was offered a snack. The outcome stated improvement. 12/8/13 - Being short tempered, easily annoyed, behaviors not directed at others and verbal behavioral symptoms directed toward others, and unknown cause. The interventions were the resident was assisted to area of choice, offered a snack and provided a diversionary activity. The outcome documented no change. 12/14/13 - Being short tempered, easily annoyed, behaviors not directed at others and unknown cause. The interventions were the resident was offered a snack, provided a diversional activity, provided reassurance, had 1 to 1 interaction with staff. The outcome was no change. Note: The CP interventions did not include to assist the resident to an area of choice or offer a snack. The resident's 11/4/13 activity program documented "The resident has little or no activity involvement related to Lupus, Depression, Dementia...resident tires easily and usually desires to be in bed between meals." The following observations documented Resident #2 spent most of her time in her room in bed. The room was observed to be dark with the lights off and the blinds closed. The resident seldom ate her meals with other residents in the dining room and was not observed to participate in any	F 329		

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	135092		C 12/20/2013

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F 329	Continued From page 45 activities. Observations included: 12/16/13 -4:40 p.m. - The resident was in bed, the room was dark with the light off and blinds closed. 12/17/13 -8:35 a.m. - The resident returned from the dining room and requested the surveyor make the bed so she (resident) could go to bed. At 9:30 a.m. 11:15 a.m.,12:23 (lunchtime), 12:50 p.m. and 3:00 p.m. the resident was observed in bed. The room was dark with the light off and the blinds closed. 12/18/13 - At 8:00 a.m. the resident was in bed, at 12:00 (lunchtime) a physical therapist came in and said he was going to take her to the dining room. At 5:45 p.m. (evening meal time) the resident was in bed. The room was dark with the light off and the blind closed 12/19/13 - At 8:00 a.m., 8:20 a.m. and 9:05 a.m. the resident was observed in bed. On 12/18/13 at 1:30 p.m. the surveyor met with the social worker and asked how "to encourage to participate in activities" could be an effective intervention if the resident did not want to participate in activities. The Social Worker stated the non-pharmalogical intervention needed to be clarified. 3. Resident #8 was admitted to the facility on 6/10/11 and readmitted on 5/25/12 with diagnoses which included insomnia, generalized pain, anxiety state and depressive disorder. Resident #8's Medication Review Report for 12/13 (physician recapitulation orders) included	F 329		

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F 329	Continued From page 46 an order for Prozac (antidepressant) 40 mg daily with an order date of 7/3/12 and Abilify (antipsychotic) 30 mg daily related to schizophrenia with a start date of 9/30/13. The resident's 10/29/13 CP for depression documented the resident received an antidepressant medication. The intervention section identified a Black Box warning to observe for increased risk of suicidal thinking and other side effects. The intervention section did not identify the signs and symptoms demonstrated when the resident was depressed, to monitor and document if the resident was depressed, what to do if the resident was depressed or to notify the nurse of the resident's depression. The only information in the intervention section was the Black Box warning. The resident's 10/29/13 antipsychotic CP intervention section included to monitor for "symptoms that are significant enough that the resident is experiencing inconsolable or persistent distress (e.g., fear continuously yelling and distress associated with end of life or crying). The intervention section also included the Black Box warning. On 12/18/13 at 1:00 p.m. the Medical Record Supervisor stated there was no documentation of behaviors for the resident. On 12/18/13 at 1:30 p.m. the surveyor met with the social worker and informed her of the above concerns. The facility provided no further documentation for behaviors of yelling or distress for the use of the antipsychotic medication, or documentation of symptoms of depression.	F 329		

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F 329	Continued From page 47 4. Resident #6 who is more than 75 years old, was admitted to the facility on 5/24/12 with multiple diagnoses including muscle weakness, psychosis and depression. Resident #6's December 2013 MAR documented, with a start date of 11/15/13, "Seroquel tablet Give 100 mg by mouth one time a day for antipsychotic related to OTH[er] PERSISTENT MENTAL D/O [disorder]..." The MAR documented the resident had received the medication as ordered. The Resident's medical record did not contain documentation which informed the Resident or the Resident's POA of common side effects listed for Seroquel, including a black box warning of increased risk of death in the elderly. 5. Resident #11 who is more than 85 years old, was admitted to the facility on 5/23/12 with multiple diagnoses including muscle weakness, subdural hemorrhage and hypertension. Resident #11's December 2013 MAR documented, with a start date of 11/26/13, "RisperDAL Tablet Give .5 mg by mouth two times a day for agitation with dementia related to OTH[er] PERSISTENT MENTAL D/O [disorder]..." The MAR documented the resident had received the medication as ordered. The Resident's medical record did not contain documentation which informed the Resident or the Resident's POA of common side effects listed for Risperdal, including a black box warning of increased risk of death in the elderly.	F 329		

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F 329	Continued From page 48 On 12/19/13 at 1:30 PM the DNS was interviewed regarding informing the residents or responsible party about the black box warnings. The DNS stated, "We don't have documentation like that." She also said the facility feels the warning should come from the doctor and not the facility. On 12/19/13 at 4:35 PM, the Administrator, DNS, Social Services, and Case Manager were informed of the risks of medication issues. No further information was provided. 6. Resident #7 was admitted to the facility on 1/14/13 and readmitted on 5/24/13 with multiple diagnoses which included depressive disorder. Resident #7's Care Plan, dated 11/18/13, documented in part: * Focus - "The resident is on antidepressant medication therapy R/T (related to) mood E/B (evidenced by) self isolates;" and, * Interventions - "Monitor for increased risk for falls; BLACK BOX WARNING - Effexor (venlafaxine): Observe for increased risk of suicidal thinking and behavior." The December 2013 Medication Record for Resident #7 documented in part: * "Venlafaxine HCl Tablet Give 150 mg by mouth one time a day for depression related to DEPRESSIVE DISORDER NOT ELSEWHERE CLASSIFIED..." The Medication Record documented the resident had received the medication as ordered. On 12/19/13 at 1:32 p.m., the DNS was asked when venlafaxine was started, what target behaviors were being treated, why was the medication indicated, how the effectiveness of the medication was being monitored, and what	F 329		

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F 329	Continued From page 49 non-pharmalogical interventions were tried and monitored. The DNS stated, "I will see what I can find for you." On 12/19/13 at 2:03 p.m., the DNS returned with documentation and information that had been requested. The DNS stated, "He was already on the medication with [his] first admit" on 1/12/13. At 2:03 p.m. the DNS had provided a Behavioral Committee Drug Review form, dated 2/27/13, which documented a clarification for the indication of use for venlafaxine (Effexor), which was "depression [with] anxiety." The form also documented in part: * "Target Behaviors: #1: Rejected care. Behavior increased: #2;" * "Anti-depressant: Celexa 40 mg QD (every day) 1/14/13" and "Venlafaxine 150 mg QD 1/14/13;" and, * "Attending Physician Comments: D/C (discontinue) Celexa - assure venlafaxine is not ER (extended release) [and] [increase] to BID (two times per day)." The DNS was asked why Effexor had been increased at which she replied, "Because they dc'd [discontinued] Celexa and therefore increased Effexor." At 2:03 p.m., a second Behavioral Committee Drug Review form was provided, dated 8/28/13, which documented in part: * "Target Behaviors: #1: Little interest in doing things. Behavior increased: #[0]; #2: Appearing down. Behavior increased: #[0]; #3: Short tempered. Behavior increased: #[0]; Reject Cares. Behavior increased 2;" * "Anti-depressant: Venlafaxine HCL (Effexor) 150 mg PO (by mouth) qd (daily) Diagnosis of	F 329		

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F 329	Continued From page 50 Depression." The DNS was asked if any GDR's (gradual dose reductions) had been attempted for Resident #7 at which she replied, "Not that I'm aware of." At 2:10 p.m., the DNS was asked asked if monitoring for effectiveness of non-pharmalogical interventions had occurred, she stated, "I do not believe with our current system we have a way of doing that yet." At 2:17 p.m., the DNS was asked if the Effexor medication was monitored for effectiveness. She said she would look it up. On 12/19/13 at 2:29 p.m., the DNS provided a "Mood & Behavior Report" which documented, "Rejection of Care" on 2/7/13, 2/25/13, 4/2/13, 4/18/13, 7/8/13, and 7/25/13. Note: "Rejection of Care" was the only behavior documented and it was only documented on the dates listed above. There was no evidence the target behaviors of, "Little interest in doing things," "Appearing down," and "Short tempered" had occurred. Additionally, there was no evidence gradual dose reductions had been attempted. Behavior monitoring was inconsistent and incomplete, and there was no direction to staff on what behaviors needed monitoring and interventions to attempt in the behavior management of Resident #7. On 12/19/13 at 4:40 p.m., the Administrator, DNS, Social Services, and Case Managers were informed of the antidepressant medication issues. However, no further information or documentation was provided.	F 329		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 353 F 353 SS=E	Continued From page 51 483.30(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 a resident group interview, record review, observations, and resident and staff interviews, it was determined the facility failed to ensure there was adequate staffing to provide for the needs and well-being of all residents. This affected 6 of 13 sampled residents (#s 1, 2, 4-5, and 13), 4 random residents (#'s 21, 22, 23, and 24), and 6 of 8 residents who attended the group interview. And, it had the potential to affect all other residents who lived in the facility who required staff assistance with their ADLs. This	F 353 F 353	Please accept the following plan of correction as our credible allegation of compliance for F-353: 1. Residents #1, 4, 6, 21, 22, all residents were non-interviewable, resident #5 reports that wait time of 10 minutes is acceptable. Resident's #2 and 13 have been discharged, resident #23 passed away on 1/15/2014. 2. All residents who require staff assistance with their ADL's have the potential to be affected by this practice. 3. a. An adjustment to current staff placement to give consistent assignments to meet the needs of the residents will occur throughout the center. Review of the daily program flow and use of the areas for Helping Hands area is being investigated. We are also exploring the placement of several windows with safety glass to be placed between the Helping Hands day room and dining room to better visualize the residents throughout all areas versus placement of security cameras in the Helping Hands dining room and main hallway of helping hands to better visualize residents activities and movements. Additionally, we will be reversing the functions of the current day room and the Helping Hands	

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FACILITY STANDARDS

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F 353	Continued From page 52 failure created the potential for psychosocial and physical harm to the residents in the facility. Findings included: Observations: 1. On 12/16/13 at 4:40 PM the hallway in the Helping Hands unit was void of residents and staff. Resident #4 was heard yelling out her husband's name repeatedly. The surveyor looked in Resident #4's room and observed her on her hands and knees on the floor between the two beds. Resident #4 did not appear to be in any pain or imminent threat of injury. Resident #4 ask the surveyor for assistance to get up and the surveyor told the resident they would be right back with help. The surveyor still did not see any staff members in the hallway. The surveyor hurried down the hallway into the Lounge room and found no staff there. The surveyor then turned left, walked about 10 feet and then turned right to enter the Dining room to find two staff members there assisting residents to dining room tables for their upcoming dinner meal. The surveyor immediately notified LN #5 of the situation and she left to check, assess, and assist the resident up into her wheelchair. The resident did not complain of any pain from the incident. Note: At the time of the observation the unit had two staff members for the nine residents on the unit. The hallway where resident rooms were located could not be visually seen from the Dining room and vice versa. 2. On 12/18/13 at 3:45 PM Resident #21 was observed in the Helping Hands unit walking down the left side of the hallway toward the Lounge	F 353	dining room. The current day room will become the dining room, and the current dining room will become the activity/day room. b. All resident will be to interviewed by the LSW or designee to determine a bath schedule that is suitable to the residents desires and needs. If resident declines a scheduled bath, alternatives will be offered, such as a sponge or bed bath. c. Call lights will be answered within 15 minutes, if additional assistance is needed for specific ADL task, the call light will remain on until a second staff member can provide assistance. d. Staff will be re-educated beginning 1/29/2014 and completed no later than 2/3/2014 that call lights are to remain on until a resident's care needs are met. e. Licensed nursing staff was re-educated on 1/9/2014 to assure that all residents are offered and assisted as needed with bedtime snacks. Additional snack carts will be available for the licensed nurse to distribute or delegate the distribution of the bedtime snacks by CNA's.	

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F 353	Continued From page 53 area. The resident appeared confused and said he needed to use the bathroom to urinate. LN #6 was standing about 15 feet away next to the medication cart in the Lounge room in full view of the hallway. The resident stopped outside of the door to the nurses station, which contained a bathroom off of the room. LN #6 told the resident, "You can go in there." The resident still appeared to be confused and instead of entering the bathroom, he walked toward LN #6. The surveyor inquired why Resident #21 did not receive assistance to direct him into the bathroom. LN #6 said she could not leave the other residents in the Lounge room unattended because the only CNA on duty on the unit was assisting another resident in their room. When asked what would happen if there was a situation where she was alone to watch residents and a resident emergency occurred, like a fall with injury, LN #6 said she would call another unit to send someone down. She produced a cell phone from her pocket to show she had the ability to call someone to assist. Note: During the observation above, LN #6 did not call another unit to assist with Resident #21 nor was the resident assisted to the toilet from 3:45 PM to 3:53 PM, when the surveyor had to leave the unit. 3. On 12/18/13 from 5:10-5:23 PM in the Helping Hangs unit, LN #6 was assisting Resident #11 with her meal. Resident #11 appeared to take a break and moved away from the table. LN #6 then took a meal tray off the tray cart and left the dining room, leaving CNA #1 alone in the dining room with the other seven residents. LN #6 took the tray into Resident #6's room and found Resident #22 already in the room. (Note: The	F 353	4. Beginning 1/20/2014, Case Manager or designee will audit call lights for trending, and assure that staffing meets or exceeds state guidelines. Case manager or designee will also as previously mentioned in F-246, F-280, and F-312, assure that the resident has the freedom to choose their bath days, specific interventions if they decline or refuse their bath, and that they are receiving their bath per their preference, and their refusals are appropriately addressed. Audits will be completed q week x 4, q 2 weeks x 4, q month x 3, and quarterly x 2. All audit results will be reported to QA/CQI for furthering monitoring and recommendation. 5. Compliance will be achieved on or before 2/12/2014.	2/12/2014

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F 353	Continued From page 54 cognitively impaired residents did not share a room.) Resident #6 was heard telling Resident #22 her food was not in the room. Resident #6 did not appear to be in distress over the incident. LN #6 placed the tray down for Resident #6 and then assisted Resident #22 out of the room and back into her room and asked if she needed to use the bathroom and the resident said, "No." Note: Resident #22 was in Resident #6's room for an undetermined amount of time since the two staff members and surveyor were in the Dining room and could not visually see the hallway leading to resident rooms. 4. On 12/19/13 at 7:25 a.m., the survey team entered the facility and heard a call light alarming. The dashboard at the nurse's station displayed the call light was for room 102 and had been alarming for 22 minutes and 50 seconds. The call light was answered at 7:28 a.m., over 26 minutes since it began alarming. Note: See F246 regarding call light information. Documentation: 1. On 12/18/13 a list of residents requiring two person assistance was requested and reviewed. The document listed 57 resident names and a handwritten '2' next to residents who required two person assistance with ADL's. Of the 57 residents, 26 residents in the facility required two person assistance. Of the 26 residents, 15 resided on the 100 hallway, 5 were on the Helping Hands unit, and there were 3 each on the 200 and 300 hallways. 2. On 12/19/13 a call light audit from 12/1/13 to 12/19/13 for Resident #5's room was requested	F 353		

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F 353	Continued From page 55 and reviewed. Call light wait times for 7 out of 19 days, ranged from 17 minutes and 22 seconds to 37 minutes and 9 seconds. 3. On 12/19/13 a call light audit from 12/1/13 to 12/19/13 for Resident #23's room was requested and reviewed. Call light wait times for 7 out of 19 days, ranged from 18 minutes and 15 seconds to 28 minutes and 2 seconds. 4. On 12/19/13 a call light audit from 12/1/13 to 12/19/13 for Resident #24's room was requested and reviewed. Call light wait times for 9 out of 19 days, ranged from 17 minutes and 4 seconds to 35 minutes and 30 seconds. 5. On 12/19/13 a call light audit from 12/1/13 to 12/19/13 for Resident #8's room was requested and reviewed. Call light wait times for 7 out of 19 days, ranged from 16 minutes and 27 seconds to 29 minutes and 10 seconds. 6. On 12/19/13 a call light audit from 12/1/13 to 12/19/13 for a Resident from the group meeting, who wanted to remain anonymous, was requested and reviewed. Call light wait times for 6 out of 19 days, ranged from 24 minutes and 2 seconds to 35 minutes and 30 seconds. Note: Refer to F246 regarding additional call light information. 7. Resident #2's Bathing report for October and November 2013 documented she went without a shower twice for 7 days and once for 14 days. 8. Resident #8's Bathing report for November 2013 documented she went without a shower twice for 7 days.	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135092		C 12/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE	840 EAST ELVA STREET IDAHO FALLS, ID 83401

(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 353	Continued From page 56 9. Resident #1's Bathing report for December 2013 documented she went without a shower twice for 7 days. 10. Resident #13's Bathing report for December 2013 documented she went without a shower twice for 7 days. Note: Refer to F312 regarding bathing issues. Resident Interviews: 1. On 12/17/13 at 9:43 AM Resident #5 was interviewed regarding staffing levels. The resident said she often waited for long periods of time after turning on her call light and stated, "They just say we will try to get someone to help you, but they don't come back." When asked to clarify this statement she said the staff will sometimes come in and turn off the call light and leave without assisting the resident, then when no one comes back after a few minutes, the resident turns on the call light again. The resident said the call light situation has upset her so much she has cried about it on a few occasions and stated, "We don't have enough help." Note: Refer to F246 and F315 regarding call light and incontinence care information. 2. On 12/17/13 at 9:50 a.m. Resident #8 was interviewed regarding call light response times and she said she was left on the toilet for one hour. The resident also stated the aides will come in turn the call light off and state they will come back, but they do not come back. 3. During the meeting with the residents, on 12/17/13 at 1:20 p.m., 3 of 8 residents in attendance stated they had to wait 30 minutes, "Once in a while" for their call light to be	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE	840 EAST ELVA STREET IDAHO FALLS, ID 83401

(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 353	Continued From page 57 answered. 2 of 8 residents stated they had to wait 20 minutes for their call light to be answered "Pretty often." When asked what pretty often meant, they stated more than one time a week. The residents also stated early in the morning was when they had to wait longer. Also during the meeting with the residents, at least 2 of the residents stated there were not enough staff to ensure showers were given. One of the residents stated they did not receive baths as scheduled. The resident stated he/she, "Has to push the issue to get a bath." Residents also reported they may be offered a bath but not until 8:00-9:00 p.m., which was too late. 4. On 12/17/13 at 9:50 a.m. Resident #8 stated she was to be showered twice a week. The resident stated if the facility was "short on aides" she would not get a shower and had missed showers the month of November. The resident added it bothered her when she did not get a bath. Note: Refer to F246 and F312 regarding call light and bathing information. Staff Interviews: 1. On 12/16/13 at 3:00 PM, CNA #14 was interviewed regarding staffing levels and she said she was on light duty and could only use her right hand, which made it difficult while transferring residents. 2. On 12/16/13 at 4:47 PM, LN #5 was interviewed regarding sufficient staffing levels. She said there is always at least one CNA and one LN on the Helping Hands unit. When asked	F 353		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE	840 EAST ELVA STREET IDAHO FALLS, ID 83401

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F 353	Continued From page 58 what did staff do when they needed another staff member to assist with residents, she stated they, "Can call another aide but that takes time." When asked how long that generally took, she said about 10 to 15 minutes. When asked where the extra aide comes from, she said usually from the rehabilitation unit. 3. On 12/17/16 at 8:35 AM, CNA #15 was interviewed regarding staffing levels and she said the facility did not have enough staff. She also said residents had to wait for 15 to 20 minutes and sometimes longer before they received assistance from staff. 4. On 12/18/13 at 5:05 p.m., the surveyor stated to CNA #12, "You appear to be very busy," at which the CNA responded, "We're pretty rushed." The CNA said showers were performed from 2:00 to 5:00 p.m. and after dinner if they had time, but most residents went straight to bed after dinner. When asked how many showers needed to be done per day, the CNA stated, "Five to six." CNA #12 said they started to get residents up at 4:00 p.m. to have them all up by 5:00 p.m. for dinner. The CNA said they usually had three CNA's working but it was not enough and added, "Four CNA's is a good day." When asked if the staff passed bedtime snacks, CNA #12 stated, "We don't really have time." 5. On 12/18/13 at 5:28 p.m., CNA #13 was interviewed about bedtime snacks. The CNA stated, "We do try. We don't have time." CNA #13 said she usually worked in the Helping Hands secured unit or Rehabilitation unit. When asked why she was working on halls 1 and 3, the CNA responded, "They're short." The CNA said two CNA's were needed on each hall (hall 1 and hall	F 353		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE	840 EAST ELVA STREET IDAHO FALLS, ID 83401

(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 353	Continued From page 59 3) and that it was so stressful they couldn't do resident care well. Note: Refer to F368 regarding evening snacks. 6. On 12/19/13 at 9:20 AM, CNA #7 was interviewed regarding sufficient staffing. She said she assisted on other units when they needed her and usually helped with hallway 1. When asked when she is pulled from her unit, who covered the work she left behind, she stated, "It's hard to do both sometimes," but said she does her best to cover both units. When asked if it always worked out to cover both areas, she stated, "Sometimes I have to stay on the unit," she was pulled to. When asked what happened then, she said sometimes she can pick up some extra time to help out, but the residents do not always get all the care they needed. 7. On 12/19/13 at 10:04 a.m., LN #6 was asked how staff know when a call light is alarming and which room it belonged to. The LN stated they could, "Hear it. [They] also look at the dashboard" to see who's light was going off the longest. On 12/19/13 at 2:50 p.m., the DNS was interviewed about staffing in the facility. She stated, "Currently, we have been reviewing staffing on a daily need. Right now we have three staff members, CNA's, plus a restorative CNA, and of course the nurses to assist residents with the front (halls 1 and 3). We have some of our other staff that float to rehab and helping hands" which were case managers and human resources. The DNS continued, "In the evenings its the same things with CNA's. 2 on the front, 1 in helping hands, 1 in rehab, and then we have the floor nurses." When asked if the facility had enough staff to get residents up and toileted	F 353		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE	840 EAST ELVA STREET IDAHO FALLS, ID 83401

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F 353	Continued From page 60 around meal times, the DNS responded, "I have not seen a problem currently with them being able to do that." During the interview the DNS was asked and/or shown information regarding the following: -She was shown the results of the call light audits for Resident #5 & #8 and the DNS did not respond, but took notes; -She was informed about what the group interview revealed and she did not respond, but took notes; -She was informed about the observation regarding Resident #4 and asked how she made sure resident needs were being met on the Helping Hands secured unit during meal times and she stated, "My understanding is, they do go by to check on them (the residents) periodically."; -She was informed of the other two observations (see Observations above) in the Helping Hands unit and she did not respond, but shook her head up and down and took notes; -She was informed about residents who did not receive baths and she did not respond, but took notes; -She was also informed about residents who did not receive evening snacks and she did not respond but took notes. When asked why no comments were made regarding several of the issues identified, the DNS stated, "I'm taking notes so I can look into it a little bit more." On 12/19/13 at 4:35 PM, the Administrator, DNS, Social Services, and Care Manager were informed of the issues. No further information was provided.	F 353		
F 368	483.35(f) FREQUENCY OF MEALS/SNACKS AT	F 368		

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F 368 SS=E	Continued From page 61 BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and resident interview, it was determined the facility failed to ensure residents were offered a snack at bedtime for 3 of 13 sample residents (#s 2, 3, and 8) and 5 of 8 residents who attended the Resident Group meeting with the surveyors. This had the potential for harm as the lack of a bedtime snack may result in feelings of hunger and diminished nutritional status of residents. Findings included: 1. On 12/17/13 at 1:20 PM, the resident group was asked about bedtime snacks. Five of 8 residents present stated they were not offered a snack at bedtime, but they could request a snack.	F 368	Please accept the following plan of correction as our credible allegation of compliance for F-368: 1. Resident's #3 and 8 will be offered snacks by LN or CNA at bedtime, resident #2 was discharged on 12/19/ 2013. 2. All residents have the potential to be affected by this practice. 3. Licensed nurses will be educated to provide bedtime snacks to residents during bedtime medication pass. This task may also be delegated to the C.N.A. Staff will be educated at meetings on 1/16/2014 and 1/17/2014. 4. Beginning 1/20/2014, Case Manager or designee will audit documentation that all resident are offered bedtime snacks. Audits will be completed q week x 4, q 2 weeks x 4, q month x 3, quarterly x 2. All audit results will be reported to QA/CQI for further monitoring and recommendation. 5. Compliance will be achieved on or before 2/12/2014	2/12/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 368	Continued From page 62 2. Resident #8 was admitted to the facility on 6/10/11 and readmitted on 5/25/12 with diagnoses which included insomnia, generalized pain, anxiety state and depressive disorder. On 12/17/13 at 9:50 p.m. Resident #8 stated she was not offered a bedtime snack consistently. On 12/18/13 at approximately 2:00 p.m. the Medical Record Supervisor (MRS) stated the bedtime snacks were documented on the "Dining Report" (DR) for each resident. The report documented the 3 meals served each day and if a between meal a.m. snack or a between meal p.m. (bedtime snack) was offered to the resident. Resident #8's DR form did not document a bedtime snack was offered any day in 10/2013, was offered 2 times in 11/2013 and had not been offered between 12/1/13 and 12/18/13. 3. Resident #2 was admitted to the facility on 8/3/13 with diagnoses which included pressure ulcers, dementia without behavioral disturbance and depressive disorder. Resident #2's DR form documented for 10/2013 the resident was offered a bedtime snack 5 times, for the month of 11/2013 the resident was offered a snack 3 times and for 12/1/13-12/17/13 the bedtime snack was offered 1 time. 4. Resident #3 was admitted to the facility on 11/24/10 with diagnoses that included depressive disorder and unspecified psychosis. Resident #3's DR form documented for 10/2013 the resident was offered a bedtime snack 3 times, for the month of 11/2013 the resident was offered	F 368		

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GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE	840 EAST ELVA STREET IDAHO FALLS, ID 83401

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F 368	Continued From page 63 a snack 1 time and for 12/1/13-12/17/13 a bedtime snack was not offered. 5. On 12/18/13 at 5:05 p.m., the surveyor stated to CNA #12, "You appear to be very busy," at which the CNA responded, "We're pretty rushed." When asked if the staff passed bedtime snacks, the CNA stated, "We don't really have time." On 12/18/13 at 5:28 p.m., CNA #13 was interviewed about bedtime snacks. The CNA stated, "We do try. We don't have time." On 12/19/13 at 4:40 p.m., the Administrator, DNS, Social Services, and Case Managers were informed of the HS snack issue. However, no further information or documentation was provided.	F 368	Please accept the following plan of correction as our credible allegation of compliance for F-371: 1. In regards to residents # 1-9, (1) the ice machine has been cleaned per facility procedure, (2) beard/hair covers are available to staff that require them, and (3) dietary manager/designee has gone through dishes and all cups and bowls with pitting have been disposed of. 2. All residents who dine in the facility have the potential to be affected by this practice. 3. Staff will be re-educated to (1) clean ice machines per policy, (2) assure that all food employees hair and facial hair are restrained appropriately using hair nets, hats, beard restraints, and (3) only microwave foods in approved containers, dietary manager or designee will assure that plates, bowls and cups are free from pitting or irregular surface which may present an exposure to contamination and/or food borne illness. Staff will be educated at meetings on 1/16/2014 and 1/17/2014.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure food was stored, prepared, and served under sanitary conditions. This had the potential to affect 9 of 9	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135092		C 12/20/2013

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GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE	840 EAST ELVA STREET IDAHO FALLS, ID 83401

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F 371	Continued From page 64 sample residents (#s 1-9) and all other residents who dined in the facility. This failure created the potential for cross contamination of food and for residents to be exposed to foodborne illness. Findings include: Note: The 2009 FDA Food Code Chapter 2, Hair Restraints, subpart 2-402.11 Effectiveness, indicated, "(A) Except as provided in ¶ (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles." On 12/16/13 at 1:15 p.m. during an initial tour of the facility's kitchen, and with the Dietary Manager (DM) in attendance, the following conditions were observed: 1. The ice machine had a thin layer of dust and food crumbs on the ledge above the door to the machine to access the ice. 2. Cook #1's beard was not covered by any type of hair restraint during the tour of the kitchen. The DM acknowledged the cook's beard was not covered and stated she would order some beard restraints. 3. Four of 12 plastic cups were observed to be pitted in the bottom of the cup, causing an un-cleanable surface. The DM tossed the cups in the garbage at that time.	F 371	4. Beginning 1/20/2014, Dietary Manager or designee will audit dietary staff for compliance, (1) ice machines are cleaned according to departmental procedure, (2) all food employees are compliant with wearing hair nets/covers, and beard restraints, and (3) inspection of dishes for absence of pitting (non-cleanable surface), inspect resident accessible equipment for cleanliness. Audits will be completed q week x 4, q 2 weeks x 4, q month x 3, and quarterly x 2. All audit results will be reported to QA/CQI for further monitoring and recommendation. 5. Compliance will be achieved on or before 2/12/2014	2/12/2014

PRINTED: 01/09/2014
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	MDS001310		C 12/20/2013

NAME OF PROVIDER OR SUPPLIER: GOOD SAMARITAN SOCIETY - IDAHO FALLS \

STREET ADDRESS, CITY, STATE, ZIP CODE: 840 EAST ELVA STREET, IDAHO FALLS, ID 83401

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the State licensure and complaint survey of your facility. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Lauren Hoard, RN, BSN Sherri Case, LSW, QMRP	C 000	Refer to federal Plan of Correction RECEIVED JAN 22 2014 FACILITY STANDARDS	
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: Refer to F353 related to adequate staffing levels to meet residents' needs.	C 111	Please accept the following plan of correction as our credible allegation of compliance for C-111: Please see F-353 above	
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 regarding clothing protectors and medication given during a meal.	C 125	Please accept the following plan of correction as our credible allegation of compliance for C-125: Please see F-241 above	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 1/22/2014

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	MDS001310		C 12/20/2013

NAME OF PROVIDER OR SUPPLIER: GOOD SAMARITAN SOCIETY - IDAHO FALLS \

STREET ADDRESS, CITY, STATE, ZIP CODE: 840 EAST ELVA STREET, IDAHO FALLS, ID 83401

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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 sanitation practices.	C 325	Please accept the following plan of correction as our credible allegation of compliance for C-325: Please see F-371 above	
C 411	02.120,05,k All Resident Rooms Numbered k. All patient/resident rooms shall be numbered. All other rooms shall be numbered or identified as to purpose. This Rule is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 6 rooms in the facility were labeled. This had the potential to effect the residents or visitors who resided or came to the facility. Findings included: On 12/16/13 from 2:27 to 3:08 PM a tour of the facility was completed. The six rooms did not have any identification on them. On 12/17/13 at 9:00 AM, the Administrator was shown these rooms and she identified them as storage rooms and said she would place temporary signs on the doors. On 12/17/13 at 2:50 PM, the Administrator was seen placing 'Storage Room' signs on the doors in question.	C 411	Please accept the following plan of correction as our credible allegation of compliance for C-411: 1. Temporary signs were placed on the 5 storage rooms, and 1 clean linen storage room. Permanent signs have been ordered and will be place upon arrival. 2. All residents, staff and visitors have the potential to be affected. 3. All room will be correctly identified as to purpose. 4. Beginning 1/20/2014, Case Manager or designee will assure that all room will be identified correctly as to purpose. Audits will be completed q week x 4, q 2 weeks x 4, q month x 3, quarterly x 2. All audit results will be reported to QA/CQI for further monitoring and recommendation. 5. Compliance will be achieved on or before 2/12/2014	2/12/2014

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	MDS001310		C 12/20/2013

NAME OF PROVIDER OR SUPPLIER: GOOD SAMARITAN SOCIETY - IDAHO FALLS \

STREET ADDRESS, CITY, STATE, ZIP CODE: 840 EAST ELVA STREET IDAHO FALLS, ID 83401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 412	Continued From page 2	C 412		
C 412	02.120,05,l Cold Water Drinking Fountain Requirements l. A drinking fountain connected to cold running water and which is accessible to both wheelchair and nonwheelchair patients/residents shall be located in each nursing or staff unit. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not have a working drinking fountain located in the Helping Hands unit which was connected to cold running water. Findings included: On 12/16/13 at 4:38 PM, the drinking fountain in the Helping Hands unit was observed to not work. On 12/18/13 at 3:55 PM, during the environmental tour the non-operable water fountain was shown to the Assistant Maintenance Director who tested it and stated, "I was not aware of that." On 12/18/13 at 6:30 PM, the DNS, Social Services, and CM #4 were informed of the issues. No further information was provided.	C 412	Please accept the following plan of correction as our credible allegation of compliance for C-412: 1. Drinking fountain was turned on and is functioning. 2. All residents in the unit have the potential to be affected. 3. The water fountain will remain on. 4. Beginning 1/20/2014, Case Manager or designee will assure that the drinking fountain is working. Audits will be completed q week x 4, q 2 weeks x 4, q month x 3, and quarterly x 2. All audit results will be reported to QA/CQI for further monitoring and recommendation. 5. Compliance will be achieved on or before 2/12/2014	2/12/2014
C 779	02.200,03,a,i Developed from Nursing Assessment i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Refer to F272 regarding side rail safety assessments.	C 779	Please accept the following plan of correction as our credible allegation of compliance for C-779: Please see F-272 above	

Bureau of Facility Standards

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C 782	Continued From page 3	C 782		
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 as it relates to revising care plans.	C 782	Please accept the following plan of correction as our credible allegation of compliance for C-782: Please see F-280 above	
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Refer to F309 as it relates to following physician orders and care plan instruction.	C 784	Please accept the following plan of correction as our credible allegation of compliance for C-784: Please see F-309 above	
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: Please refer to F312 as it relates to personal hygiene.	C 785	Please accept the following plan of correction as our credible allegation of compliance for C-785: Please see F-312 a	
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the	C 788	Please accept the following plan of correction as our credible allegation of compliance for C-788: Please see F-328 above	

Bureau of Facility Standards

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C 788	Continued From page 4 attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F328 as it relates to oxygen therapy and management per physician's order.	C 788		
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 pressure ulcer prevention and treatment.	C 789	Please accept the following plan of correction as our credible allegation of compliance for C-789: Please see F-314 above	
C 797	02.200,03,c Documentation of Nursing Assessments c. Nursing staff shall document on the patient/resident medical record, any assessments of the patient/ resident, any interventions taken, effect of interventions, significant changes and observations and the administration of medications, treatments and any other services provided. Entries shall be made at the time the action occurs and shall be signed by the person making the entry and shall provide the time and date of the occurrence. At a minimum, a monthly summary of the patient's/resident's condition and reactions to care shall be written by a licensed nursing staff person.	C 797	Please accept the following plan of correction as our credible allegation of compliance for C-797: Please see F-309 above	

Bureau of Facility Standards

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C 797	Continued From page 5 This Rule is not met as evidenced by: Refer to F309 as it relates to pain assessments per care plan instruction.	C 797		

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
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January 27, 2014

Susan E. Jones, Administrator Designee
Good Samaritan Society - Idaho Falls Village
840 East Elva Street
Idaho Falls, ID 83401-2899

Provider #: 135092

Dear Ms. Jones:

On **December 20, 2013**, a Complaint Investigation survey was conducted at Good Samaritan Society - Idaho Falls Village. Bradley Perry, L.S.W., Lauren Hoard, R.N. and Sherri Case, L.S.W., Q.M.R.P. conducted the complaint investigation. This complaint was investigated during the annual Recertification and State Licensure survey conducted on December 16 through December 20, 2013.

The following observations were made:

- Response time to call lights;
- Staffing levels for residents' needs; and
- The oral health of nine residents.

The following documents were reviewed:

- Call light audits in December 2013 of five residents' rooms;
- Nurse Staff hours from November 23 to December 13, 2013;
- A list of residents requiring at least two staff members to assist them;
- Facility's grievance logs from June to December 2013;
- Resident Council meeting minutes for September, October and November 2013;
- Bathing records of five residents;
- Oral health records of three residents;
- Incident and accident reports for nine residents from June to December 2013; and

- The entire medical records of four residents.

The following interviews were conducted:

- Eight residents in a group interview were asked about call lights, staff response times, oral care, bathing and snack frequency;
- Six individual residents were interviewed regarding at least one of the issues in regards to call lights, staff response times, oral care, bathing and/or snack frequency;
- One residents' family member was interviewed about staff response times and bathing frequency;
- Eight staff members were interviewed regarding staffing numbers, bathing and snack frequency;
- The Director of Nursing Services and one other registered nurse was interviewed regarding call lights, staff response times, oral care, bathing and snack frequency; and
- A unit manager was interviewed regarding the treatment of pressure sores for two residents.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006290

ALLEGATION #1:

The complainant stated the facility is too understaffed to take care of the residents' needs, especially in hallways one and three.

FINDINGS:

Based on observations, records reviewed, residents interviews and staff interviews it was determined that the facility failed to provide adequate staffing levels to meet the needs of residents in the facility; when call lights were not answered in a timely manner, residents needs were not met when they needed staff assistance and when staff indicated they did not have the time to take care of all the residents' needs. The facility was cited at F353 for failure to provide adequate staffing levels to meet the needs of residents.

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

ALLEGATION #2:

The complainant stated that about two-weeks prior to the complaint, an identified resident broke

her leg after staff rushed to transfer the resident with a mechanical lift.

FINDINGS:

The entire medical record of the identified resident and the records of three other residents were reviewed for mechanical lift transfers.

Transfers of three residents were observed.

A facility incident report was reviewed for the identified resident.

One resident was interviewed regarding mechanical lift transfers.

Two CNAs and a case manager were interviewed regarding the alleged incident and proper turning procedures.

Based on the medical record of the resident and staff interviews, it was determined that the identified resident's leg was not broken due to an improper transfer with a mechanical lift. Since the complainant is the not the resident's representative, no further details will be given regarding the resident's medical condition.

Based on the review of other residents' records, observations of mechanical lift transfers and interviews of residents and staff; it was determined the facility was properly transferring residents.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated an identified resident developed pressure sores due to improper nursing procedures, and the pressure sores were not covered for two days.

FINDINGS:

The entire medical record of the identified resident and one other resident's record were reviewed for pressure sore treatment.

During observations of the identified resident and one other resident, it was determined the facility was not following the pressure sore care plans.

The case manager was interviewed regarding interventions and treatment for pressure sores.

Based on observations, records reviewed and staff interview, it was determined the facility failed to provide the necessary nursing care and services to prevent pressure ulcers and treat existing pressure ulcers. However, it could not be determined that the identified resident developed new pressure sores due to improper nursing procedures. The facility was cited at F314 for non-compliance.

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

ALLEGATION #4:

The complainant stated that due to staff shortages, an identified resident cried after not receiving a scheduled bath and other residents were not always receiving their scheduled baths. The complainant stated the facility knew about the bath issue because residents and family members complained about the issue.

FINDINGS:

Bathing records were reviewed for six residents.

Nine residents were interviewed during the group interview, and two of the residents complained about not receiving baths as scheduled. Four residents were interviewed individually regarding bathing issues. One resident's family member was interviewed about bathing frequency. In addition, two CNAs and two case managers were interviewed about bathing frequency and procedures.

Based on records reviewed, residents attending the group meeting, residents and staff interviews, it was determined that the facility did not ensure residents received baths as needed and scheduled. The facility was cited at F312 for non-compliance.

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

ALLEGATION #5:

The complainant stated an identified resident was left on the toilet for an hour, and the incident made her upset and she cried about it. The complainant stated that another identified resident also cried after not having her call light answered for over an hour. The complainant stated call

lights throughout the facility sometimes took 20 minutes and up to an hour to be answered.

FINDINGS:

The response time to call lights was observed.

December 2013 Call lights audits on four residents' rooms and the Resident Council meeting minutes for September, October and November 2013 were reviewed.

Eight residents in a group interview were asked about call lights and staff response times; five out of eight said call lights took too long to be answered. Two residents were interviewed individually about call lights and staff response times. In addition, the Director of Nursing Services (DNS) was interviewed regarding call lights and staff response times.

Based on observations, records reviewed, residents' interviewed and staff interviews; the facility failed to provide adequate staffing levels to meet the needs of residents in the facility by being left on the toilet for extended periods of time and not answering call lights in a timely manner. The complaint was substantiated, and the facility was cited at F246 related to failure to accommodate the needs of residents and F353 for failure to ensure sufficient staff to meet residents' needs.

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

ALLEGATION #6:

The complainant stated teeth are not being brushed for anyone in the facility and only dentures were being cleaned by soaking them.

FINDINGS:

Oral health was observed for nine residents.

Oral health records of three residents were reviewed.

Eight residents interviewed in the group interview about oral health practices in the facility said they received proper oral care.

Three residents asked individually about oral health practices said they received proper oral care.

The Director of Nursing Services was asked about oral care and she said residents received proper oral care.

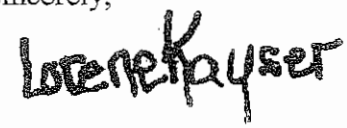
Based on records reviewed and residents and staff interviews, it was determined the facility was in compliance with Federal guidelines.

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 or concerns regarding our investigation, please contact us 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.M.R.P., Supervisor
Long Term Care

LKK/dmj