IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

February 22, 2016

Brian Davidson, Administrator
Good Samaritan Society-- Boise Village
3115 Sycamore Drive
Boise, ID 83703-4129

Provider #: 135085

Dear Mr. Davidson:

On **February 5, 2016**, a survey was conducted at Good Samaritan Society - Boise Village by the Idaho Department of Health and Welfare, Division of Licensing and Certification, 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 an isolated deficiency that constitutes actual 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. If applicable, a similar State Form will be provided 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." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) 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 the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 3, 2016**. Failure to submit an acceptable PoC by **March 3, 2016**, may result in the imposition of civil monetary penalties by **March 3, 2016**.

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

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

  If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.
- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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 **March 11, 2016 (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 **March 11, 2016**. A change in the seriousness of the deficiencies on **March 11, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 11, 2016** includes the following:

Denial of payment for new admissions effective **May 5, 2016**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, 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 **August 5, 2016**, 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, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; 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 **February 5, 2016** 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 non-compliance 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 **March 3, 2016**. If your request for informal dispute resolution is received after **March 3, 2016**, 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, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

David Scott, RN, Supervisor
Long Term Care

DJS/lj

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 federal recertification and complaint survey conducted at the facility from February 1, 2016 to February 5, 2016. The surveyors conducting the survey were: Linda Hukill-Neil, RN, Team Coordinator Juanita Stemen, RN Linda Close, RN Rachel Moorhead Lopez, MSW Survey Definitions: AD = Activity Director ADL = Activities of Daily Living cc = cubic centimeters cm = centimeters CNA = Certified Nurse Aide c/o = complained of CVA - Cerebrovascular Accident DM = Dietary Manager DON = Director of Nursing DSS = Director of Social Services ESD = Environmental Services Director ESS = Environmental Services Supervisor IU = International Unit LN = Licensed Nurse LPN/CM = Licensed Practical Nurse/Care Manager MDS = Minimum Data Set mg = milligram NOC = Night POA = Power of Attorney PEG = Percutaneous Endoscopic Gastrostomy PRN = As Needed RD = Registered Dietitian RN = Registered Nurse	F 000	**General Disclaimer** Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations manual. RECEIVED MAR - 2 2016 [illegible]	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brian L. Davida	ADMINISTRATOR	3/2/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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	Continued From page 1 X = Times	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and the facility's Abuse and Neglect policy, it was determined the facility failed to conduct a thorough investigation after receiving a complaint of a nurse hurting a resident during a urinary catheter change which caused pain and bleeding. This was true for 1 of 3 residents (#26) reviewed for indwelling urinary catheters. Findings included: Resident #26 was admitted to the facility on 6/10/13 with diagnoses that included anxiety disorder, urinary retention, and enlarged prostate. Physician orders, dated 2/1/16, documented staff were to change the resident's suprapubic catheter as needed if it became dislodged or plugged and was unable to be cleared with irrigation. A Nurse Progress Note, dated 9/15/15 and signed by RN #10, documented, "Removal of current catheter and insertion of new catheter ... tolerated procedure well."	F 226	**F226 – Abuse/Neglect** **Resident Specific** A thorough investigation was completed for resident #26 to include interviews with staff on duty during the time of the alleged incident and interviews with other residents receiving cares from RN #10. Upon notification, Resident #26's site was assessed and pain medication given. RN #10 is no longer employed at the facility. **Other Residents** All residents have the potential to be at risk if thorough investigations are not completed as it relates to abuse and neglect. Audits of all potential abuse and neglect investigations for the past six months have been completed to ensure these investigations were complete and thorough and included staff and resident interviews. **Facility System** Social Services and the Director of	**3/11/16**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 226	Continued From page 2 A Nurse Progress Note, dated 9/15/15 and signed by RN #7, documented, "Resident did c/o suprapubic cath [catheter] site pain did medicate with prn dose of Ultram ... did note small amount of blood on drain sponge that was changed this am. [Family member] did talk to staff regarding [the resident] and she was concerned about the situation of the process." The personnel file for RN #10, who no longer worked at the facility, contained a corrective action notice that documented RN #10 was suspended during an investigation for allegedly causing the resident "pain during catheter change." The facility filed a self-report, dated 9/15/15, with the State Agency that documented the allegation was not substantiated by the facility. The report did not contain a statement from RN #10 about the allegation Documentation, dated 9/24/15 and faxed to the State Agency, reported an investigation was begun when a family member told a staff member that "one of our nurses was not going to apologize to [Resident #26] for causing pain during a catheter change in August. We are surmising that the nurse was [RN #10] on the night shift although [the resident] was not able to identify her by name. There were no witnesses to the catheter change [and RN #10] did not note anything unusual on the documentation. [RN #7] was the next person to see the catheter area. He medicated [Resident #26] for pain. [The resident] has refused care from [RN #10], and he has refused care before and after the incident from other staff as well."	F 226	Nursing will review the thoroughness of each investigation to ensure we have ruled out abuse and neglect. In-servicing for Social Services will be completed by 3/11/16 regarding completing thorough investigations related to possible resident abuse and neglect. **Monitor** Starting on 3/4/16, Social Services will audit weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure thorough and complete resident abuse and neglect investigations have occurred to include interviews from staff and other residents. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification. **Date of Compliance** March 11, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 226	Continued From page 3 NOTE: Nursing Progress Notes, dated 8/30/15 through 9/15/15, documented Resident #26 refused catheter care from RN #10 on the following occassions: 8/30/15 at 3:00 a.m. 8/31/15 at 4:43 a.m. 9/1/15 at 4:43 a.m. 9/12/15 at 4:39 a.m. 9/13/15 at 3:00 a.m. 9/13/15 at 4:56 a.m. 9/13/15 at 7:05 a.m. 9/17/15 at 3:40 a.m. The facility's Abuse and Neglect policy and procedure, dated January 2016, documented: * "The center will have evidence that all alleged or suspected violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress." * "The investigation may include interviewing staff, residents or other witnesses to the incident. Interview all involved (staff, resident, and family) individually, not as a group, so that you can compare their descriptions of the incident to determine any inconsistencies. You may want to have each person write his or her memory of the event. If possible, get signed and dated statements from any witnesses." There was no documentation in the resident's record that interviews were conducted with staff on duty at the time of the alleged incident, or that interviews were conducted with other residents in Resident #26's unit. On 2/4/16 at 11:00 am, the DON was unable to locate an incident report related to the allegation.	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 226	Continued From page 4 On 2/5/16, Resident #26 stated, "That nurse hurt me. I asked her to change my catheter and she hurt me and made me bleed. I told her to stop but she kept putting it in. She didn't say anything and then just walked out of the room. I used some Kleenex that I had and patted the blood off [and] put the Kleenex in the trashcan. I told my [family member] that morning and she reported it."	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to serve meals in the dining room to non-diabetic residents at the same time diabetic residents received their meals, which was true for 9 of 44 residents (#s 3, 8, 12, 14, 20, 22, 24, 34, and 35) observed during meals. Findings included: 1. During the Resident Council Group Interview on 2/2/16 at 1:30 pm, Resident #20 stated meals were always late because diabetic residents were served first and non-diabetic residents were not served until 6:00 pm when all diabetic residents had already received their meals. Resident #34, in regards to watching their diabetic tablemates eat first, stated, "There is little communication and not knowing why we are sitting there waiting to be served."	F 241	**F241 – Dignity/Respect** **Resident Specific** Meal service has been revised to where non-diabetic residents (#s 3, 8, 12, 14, 20, 22, 24, 34, and 35) will be served at the same time as diabetic residents. **Other Residents** All non-diabetic residents were affected by not being served the same time as diabetic residents. Meal Service has been revised so all non-diabetic residents can be served at the same time as diabetic residents. **Facility System** In-servicing will be completed by 3/11/16 for dietary and nursing staff.	**3/11/16**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 241	Continued From page 5 During dinner on 2/3/16, Resident #33, who was on the facility's list of diabetic residents, was observed receiving his meal at 5:38 pm. Sitting at the opposite end of the same table as Resident #33, Resident #34, who was not diabetic, did not receive his meal until 5:45 pm. During the same dinner observation, Resident #32, who was on the facility's list of diabetic residents, was served her dinner at 5:38 pm. while non-diabetic Resident #27, sitting directly across from Resident #32, and two other unidentified non-diabetic residents sitting at the opposite end of the table from Resident #32 received their dinners at 5:45 pm and 5:50 pm respectively. During a meal service observation in the main dining room on 2/3/16 at 5:38 pm, it was noted that residents who shared a table were not served at the same time. Staff provided trays to Resident #s 7, 28, 29, 30, 31, and 32 at the beginning of meal service. Meal tickets for these residents revealed they were provided diabetic diets. It was observed that residents who were not diabetic, including Resident #s 3, 8, 12, 14, 22, 24, 34, and 35 waited an average of 10 additional minutes to be served while watching their tablemates eat at the same table. On 2/4/16 at 9:00 am, the RD, DON, and DM, stated the facility decided to serve diabetic residents first due to insulin administration. The RD said this practice began approximately two months prior to the above observations. The DM stated that some residents at the same table had to wait to be served while their diabetic tablemates received food.	F 241	Meals will be served "first-come, first-served" and everyone at that table will be served at the same time. If a resident arrives late to a table already served, that resident will be served next. **Monitor** Starting on 3/4/16, the care managers will audit the dining rooms weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure non-diabetic and diabetic residents are being served meals at the same time. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification. **Date of Compliance** March 11, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and interview, it was determined the facility failed to ensure residents' individual needs and preferences were accommodated by staff. This was true for 1 of 11 residents (#2) whose requests to have her hair dried after showering was not honored by staff; 1 of 13 residents (#9) whose hair was left longer than preferred; and 1 of 13 residents (#12) whose bathing time preference was not honored. Findings included: 1. Resident #2 was admitted to the facility with diagnoses that included CVA and Carpal Tunnel Syndrome. The most recent quarterly and annual MDS assessments, dated 8/11/15 and 11/3/15 respectively, documented the resident had severe cognitive impairment, required staff supervision for personal hygiene, and assistance from one staff member for bathing. Review of the care plan, initiated:11/25/13 and revised 7/13/15, documented the resident had an ADL self-care performance deficit related to cataracts and CVA.	F 246	**F246 – Accommodation of Needs** **Resident Specific** 1. Hair dryer has been provided for resident #2 and staff will assist with drying resident #2's hair after showers. 2. Resident #9's hair has been cut. Beauty shop has been notified and will give monthly haircuts to resident #9. 3. Bathing time for resident #12 has been adjusted to accommodate the resident's preferred bathing time. **Other Residents** All residents receiving assistance with hair drying, haircuts, and bathing have the potential to be affected. A complete audit of all residents has been completed to ensure resident's hair is being properly dried, residents are receiving timely haircuts, and residents are being bathed according to their preferred time. Care Plans and Shower Schedules have been updated accordingly.	**3/11/16**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 7 The facility's policy and procedure for Activities of Daily Living documented staff were to "provide residents with appropriate treatment and services to maintain or improve abilities in activities of daily living for the well-being of mind, body and soul. Any resident who is unable to carry out activities of daily living will receive necessary services to maintain ... personal ... hygiene ... ADLs are ... General personal, Daily Hygiene/Grooming: Care of hair." On 2/1/16 at 4:30 pm, Resident #2 was observed with her long hair pulled back into a ponytail and using a front wheeled walker to ambulate. The resident stated she received showers twice a week on Tuesday and Saturday evenings between 8:00 pm and 9:00 pm., and said, "I wash myself as best as I can, but my hair is usually left wet and they don't dry my hair at all. Sometimes in the middle of the night my hair is still wet and my pillowcase is wet. It is my preference to get my showers in the evenings, but I can't stand my hair left wet, especially when I'm trying to go to sleep. I would prefer they [staff] help me dry my hair. I like to be neat and tidy and I would rather not ask someone to help me dry my hair because it takes a long time to get other people to bed and I try to do it the best I can. Sometimes my hands and arms hurt and I just can't do it on my own. I have discomfort in my hands due to my carpal tunnel syndrome and I ' m not able to dry my own hair. I have requested the staff to help me blow dry my hair and they have said, 'We are busy putting people to bed.' They think I can do it by myself, but sometimes it's hard, so it just stays wet." On 2/1/16 at 5:00 pm, CNA #2 stated, "I wash her	F 246	**Facility System** In-servicing will be completed by 3/11/16 for nursing staff to ensure resident's hair is being properly dried, residents are receiving timely haircuts, and residents are being bathed according to their preferred time. Training will also include updating the care plans and Shower Schedules. **Monitor** Starting on 3/4/16, care managers will audit resident care plans & shower schedules weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure resident's hair is being properly dried, residents are receiving timely haircuts, and residents are being bathed according to their preferred time. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification. **Date of Compliance** March 11, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 hair. She [Resident #2] is able to wash herself, but I need to help her wash her hair." CNA #2 stated the resident sometimes combed her own hair, but "at times she says her hair is still wet so I towel dry it, but sometimes her hair is still damp. I just towel dry it." On 2/3/16, the LPN/CM said she was not aware of any resident on Resident #2's unit requesting a blow-dryer for their hair. The LPN/CM stated, "I suppose we could offer one, if one was requested, but normally we just use a towel to dry the resident's hair." On 2/4/16, the DON stated, "We have few residents with blow-dryers, but with those residents, staff does blow-dry their hair. Staff should be assisting any resident if they need help. I have never heard any complaints about her [Resident #2] not allowing staff to help her with her hair. We can get her a blow-dryer if she wants. I think her care plan should be more specific and clear to say staff is to offer to assist as needed. That should be in her care plan." 2. Resident #9 was admitted to the facility on 2/12/15 with diagnoses that included cerebral palsy and developmental delay. An MDS assessment, dated 12/23/15, documented the resident was not able to make his needs known and was totally dependent on staff for all ADLs. On 2/2/16 at 4:15 pm, Resident #9 was observed in his room in bed with long hair. RN #4 stated, "I'll put his name on the outside of the beauty shop door and she will give him a haircut."	F 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 9 Haircut service records documented the resident had received four haircuts from the time of his admission on 2/12/15, a period of one year. On 2/3/16 at 9:00 am, a family member stated at the time of admission he asked the facility to provide monthly haircuts as the resident preferred to wear his hair short and had received monthly haircuts from the group home where he resided prior to admission to the facility. 3. Resident #12's 9/22/15 MDS assessment documented moderate cognitive impairment, bathing was "somewhat important" to her, and she required the assistance of one staff member for bathing. An undated care plan documented the resident required the extensive assistance of one staff member for bathing and did not specify a preference for bathing at 5:00 am. On 2/2/16, during the Resident Council meeting at 1:30 pm, Resident #12 was observed shaking her fists in the air and shaking her head when discussing resident choices. During the interview, Resident #12 stated, "I'm 104 years old and they [staff] get me up at 5:00 am to bathe me. I want to stay in bed a little while." The facility's undated Shower Schedule documented Resident #12 received baths on night shift on Tuesdays and Fridays. The facility's Resident Rights and Activity Services policy, dated June 2012, documented, "To ensure that resident rights will be maintained in order to promote, encourage, support and enhance each resident's self-esteem and	F 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 10 promote a sense of self-worth." On 2/3/16 at 9:00 am, Resident #12 stated, "Staff get me up at 5:00 a.m. to bathe me and that is not my preference. When they come in that early in the morning, I'm sleeping and they [staff] come into my room and say, 'It's your bath day.' I've told them, 'Can you wait a while?' but if you want to get a bath, you've got to get up. I would prefer a better time. It's so early and it's difficult for me; I just can' t do it on my own anymore. I'm 104 years old and I've told the staff that I can't do it, but they don't believe me. They think because I used to be able to get up and down, then I can do it, but I just can't anymore. I need a lot of assistance and they just want to hurry me. I feel rushed sometimes to get my baths done. Yesterday [2/2/16] it was fast. She [staff] put shampoo on my hair, but my hair was dry and I told her you've got to wash it or my hair will itch all week. She [staff] just got me in and out quick and didn't let me stay in the bath but just a minute. I told her she was rushing to get me out. I like to have the warm water and bubbles and they don't dry me very well. The back of my legs are usually wet." On 2/3/16 , CNA #1 said night shift (10:00 pm - 6:00 am) staff get Resident #12 up to bathe her. CNA #1 stated, "When I come in at 6:00 a.m. she already has had her bath. I generally don't hear anything from the night shift regarding her baths. [Resident #12] does need assistance getting dressed and she is not able to propel herself in her wheelchair." On 2/4/16, the DON stated if Resident #12 refused baths on her scheduled bath days, then that was to be communicated to the nurses. The	F 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 11 DON stated that if Resident #12 didn't want her bath at the scheduled time, then the facility "could offer her another time she is comfortable with. We would just offer her a later time if that is something she preferred." On 2/4/16 at 3:25 pm, CNA #3 stated, "The night shift gives her baths. I go in at 5:00 am to wake her up and I ask her if she wants her bath. Usually her response is, 'Yes.' So I will start getting her up. Around 5:15 am, I put her in her front wheeled walker and take her to the bathtub. I have to assist her to undress and help her wash her hair, body, arms and legs then after the bath, I dry her and take her back to her room and I leave at 6:00 am. I do know at one point she was getting her baths at 9:00 am, but then she was switched to 5:00 am. I do recall there were a couple of times she didn't want to take a bath because she was tired and wanted a later bath time. I thought it was her request though to change to a 5:00 am bath time, but I'm not sure. I have to do a lot of the bath for her because she is not able to help as much anymore." On 2/4/16 at 4:25 pm, the DON stated, "Normally when someone says I prefer a shower in the morning or in the evening, then the care manager will just tell the staff and they will put it on the shower sheet. We don ' t really document it anywhere. If someone got showers at 9:00 am and now they want a shower at 5:00 am, then I would expect to see it as their preference listed on the individual care plan but I'm not seeing it on her care plan."	F 246		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES	F 248	**F248 - Activities** **Resident Specific**	**3/11/16**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 248	Continued From page 12 The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and interview, it was determined the facility failed to provide an on-going program of activities for large- and small groups, one-to-one, and self-directed activities specifically designed to meet individual interests and needs of residents. This was true for 2 of 10 residents (#s 8 and 9) reviewed for activities and created the potential to negatively affect residents' physical and psychosocial well-being. Findings included: The facility's Policy on Resident Rights and Activity Services, dated June 2012, documented, "Activity services will be provided in a manner that supports resident rights." 1. Resident #8 was admitted to the facility with diagnoses that included mild cognitive impairment, rheumatoid arthritis, lumbar compression fracture, and blindness. An Activity Interest Data Collection Tool Annual Assessment, dated 5/15/15, documented the resident enjoyed movies, listening to all types of music, board games, cards, newspaper, bingo, discussions, word games, reminiscing, conversing, Bible study, praying the rosary, visits with clergy, animals/pets, visiting with family and friends as well as staff and fellow residents, soft fabric, having people explain the color, items and	F 248	One-on-one activities are being offered for residents #8 and #9 (when not participating in group activities) according to his/her preferences and documented in the record. **Other Residents** Residents have the potential to be at risk when one-on-one activities are not being offered and documented. A complete audit of all resident's activity preferences has been completed to ensure one-on-one activities are occurring and being documented in the record. **Facility System** In-servicing will be completed by 3/11/16 for activities, nursing and social services regarding one-on-one activities for our residents and documenting such activities in the resident record. **Monitor** Starting on 3/4/16, the Activities Director will audit weekly x 4, bi-weekly x 4, and then monthly x 3 to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 248	Continued From page 13 things happening around her, having her hair and nails done, and wearing nice clothes. Resident #8 was able to make her own choices and communicate her needs to others. An undated care plan documented Resident #8 was dependent on staff for activities, cognitive stimulation, and social interaction. Staff were directed to assist with arranging community activities and provide 1-to-1 bedside/in-room visits and activities if the resident was unable to attend out-of-room events. Resident #8 enjoyed visits with family and friends, social interactions, bingo, newspaper socials, trivia, ladies night, dinner and a movie, listening to audio books in her room, and group activities. The care plan documented the resident "loves to meet new people and socialize ... offer visits with Chaplain ... offer pet visits." A one-to-one Activities Follow-up Question Report for November 2015 documented the resident was offered four one-to-one activities for the entire month. The Activities Report did not document whether Resident #8 participated in any 1:1 activities for November 2015. A one-to-one Activities Follow-up Question Report for December 2015 documented the resident was offered two one-to-one activities for the entire month. The Activities Report did not document whether Resident #8 participated in any 1:1 activities for December 2015. A Group and Self-Directed Activities Follow up Question Report for December 2015 documented the resident was offered or participated in Group/Self-Directed Activities on the following days:	F 248	ensure one-on-one resident activities are occurring and being documented. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification. **Date of Compliance** March 11, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 248	Continued From page 14 * 12/2/15 - Newspaper Social, Trivia, Gingerbread Project, Board Games and "Hee Haw" television program. * 12/4/15 through 12/6/15 - Newspaper Social, Trivia, Bingo, Snack, Movie, Supper Social, Piano/Viola Recital, Baking, Church. * 12/12/15 through 12/14/15 - Newspaper Social, Trivia, Movie, Supper Social, Games, Church, Price is Right television program, Bingo, Popcorn & A Holiday Movie, Ministry of Music. * 12/16/15, 12/17/15, 12/19/15, 12/20/15, 12/22/15, and 12/24/15 through 12/28/15 - Price is Right television program, Newspaper Social, Bell Choir Performance, Baking, Trivia, Bingo, Supper Social, Movie, Church, Popcorn & A Holiday Movie, and Ministry of Music. A one-to-one Activities Follow Up Question Report for January 2016 documented no 1:1 activities were offered to Resident #8 for the entire month. A Group and Self-Directed Activities Follow up Question Report for January 2016 documented Resident #8 was not offered or participated in Group/Self-Directed Activities from 1/2/16 through 1/11/16; 1/14/16; 1/16/16 through 1/17/16; 1/20/16 through 1/21/16; 1/24/16 through 1/25/16; and 1/27/16 through 2/2/16. Group and Self-Directed Activities offered those dates included Newspaper Social, Trivia, Movie, Supper Social, Baking, Church, Bingo, Popcorn & A Movie, Chapel, Apples-to-Apples, Dinner & A Movie, Card Group, Brain Games, Birthday Party, and Comedy Hour. On 2/2/16 at 8:00 am, Resident #8 was observed being assisted by staff with breakfast. Staff was	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 248	Continued From page 15	F 248		

observed cueing the resident where things were located on her breakfast plate.

On 2/2/16 at 8:45 am, CNA #4 stated, "She [Resident #8] cannot see so we have to cue her and tell her where things are at. She is able to voice her needs and push her call light. She likes to participate in activities and really enjoys going to Bingo and she was her own special bingo board."

During the Resident Council Group Interview on 2/2/16 at 1:30 pm, Resident #8 stated, "Unless someone reads the activity calendar to me or tells me what activities there are, then I don't know what is going on. I'm blind and hard of hearing and I would like to be informed of the activities here. I didn't even know we had a Ladies Night and I would enjoy that."

On 2/2/16 at 5:15 pm, the Activities Director stated, "She [Resident #8] can't read the activity calendar because she has a sight impairment. The CNAs and the volunteers are supposed to tell her what activities there are. She really enjoys to play bingo and enjoys cards, newspaper social, music, catholic services, and books on tape, audio books and birthday parties. She also enjoys visits from friends, one-to-one activities, pizza and movies. The Activity Director stated all staff, including CNAs activity staff are supposed to chart when the activities are provided and whether the resident participated or refused.

On 2/2/16 at 5:45 pm the DON stated, "It is my understanding that staff are to record activities on the activity sheets. I know [Resident #8] enjoys bingo as I have seen her participating, but I'm not seeing it documented that she is participating or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 248	Continued From page 16 not." On 2/3/16 at 10:15 am, with a Newspaper Social taking place in the activity room, Resident #8 was observed sitting in the recliner in her room; no staff were observed informing or offereing to take the resident to the activity. When asked how staff informed her of what activities were taking place, Resident #8 stated, "They do not always let me know. I usually have to ask employees what is on the calendar today and they tell me. It's posted on the wall, but they don ' t tell me. I'm blind so I can't see the calendar. I don't have a calendar in brail so I don't always know what activities there are. I really enjoy bingo, and supper social as well. They do not offer me one-to-one activities and I do not do any activities in my room. I do not get pet therapy and that has never been offered to me. I like dogs very much and would love to have pet therapy. I also enjoy music, classical guitar and violin and singing." When asked whether she had told staff, the resident stated, "I think I have, but I don't remember. Maybe someone will tell me of an activity taking place, but by then it may already be ending or almost over. I also enjoy books on tape and I would really prefer to know what is occurring. I need assistance with everything. Sometimes when I'm in therapy, they may have things going on that I would really enjoy, so I have to decide whether to go to therapy or something else. I did miss bingo one day because I had therapy at the same time and bingo is something I enjoy. I wasn't offered a one-to-one bingo in my room or told when the next one was. I would prefer one-to-one visits and I would hope they [staff] would come sit and talk with me and I would hate to be left out." On 2/3/16 at 10:30 am, the Activities Coordinator	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 248	Continued From page 17 stated, "We let [Resident #8] know what activities are occurring. She likes bingo, music, one to one, she likes being read to, trivia and newspaper social." When asked why Resident #8 was not participating in the then-occurring "Newspaper Social," The Activities Coordinator stated, "She's probably in therapy." At that time, Resident #8 was observed in her room with no offers from staff to attend the activity. On 2/3/16 at 10:45 am, when shown Resident #8's Activities Reports, the Activities Director stated, "We don't chart every day and if it's not charted, you won't know that she has participated, refused, or [been] offered activities." If it's not documented, then it didn't happen. Whoever is in charge of activities that are currently going on would be responsible for charting that activity for the day. Obviously, we need to work on it because you are not getting a true picture of what is taking place based on the documentation I see." 2. On 2/2/16 at 4:00 pm, Resident #9 was observed seated in the activity area. An unidentified activity aide was sitting with another unsampled resident at a round table and Resident #9 was next to the table in a reclined roll-about wheelchair. The activity aide was observed playing music and talking to the resident at the table. The surveyor observed for 15 minutes as the activity aide interacted with the resident at the table. At no time during this observation did the activity aide speak to Resident #9 or address him by his name. Review of the clinical record for Resident #9	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 248	Continued From page 18 documented he had cerebral palsy with developmental delay. An MDS assessment, dated 12/23/15, documented Resident #9 was not able to make his needs known and was totally dependent on staff for all activities of daily living. A care plan for Resident #9, dated 1/8/16, documented the resident was dependent on staff for activities, cognitive stimulation, social interaction related to potential pain/discomfort and depression, and delayed development. Approaches included one-to-one bedside/in-room visits and activities if the resident was unable to attend out-of-room events, an activities program that was meaningful and of interest such as group activities, music, TV; staff were to encourage and provide opportunities for the resident's participation. Activities records for Resident #9, dated 10/2/15 through 2/2/16, documented a total of seven activities provided in October 2015, seven activities provided in November 2015, three activities provided in December 2015, and nine activities provided in January 2016. There were no documented one-to-one activities. On 2/3/16 at 9:00 am, a family member stated Resident #9 enjoyed outings and participated in community events when residing at the group home prior to admission to the facility. The family member stated he had not been contacted for permission to take Resident #9 out of the facility for community events, but would gladly would have given permission. On 2/3/16 at 4:15pm, RN #4 stated the facility took the resident out of the facility for community events and said the reclining roll-about	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 248	Continued From page 19 wheelchair was facility van accessible. On 2/3/16 at 5:15 pm, the AD stated that she had no record of Resident #9 going to community events.	F 248	**F253 – Housekeeping/ Maintenance** **Resident Specific** Toilet in Room 606 was replaced.	**3/11/16**
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to perform maintenance services necessary to maintain the toilet in Room 606 in good condition. This was true for 1 of 72 resident rooms observed for cleanliness. This failure had the potential to affect any resident who saw the unsightly toilet in the Hoeger House. Findings included: On 2/3/16 at 2:15 pm, with the ESS and ESD present, Room #606's toilet was observed with 10 built-up, dark brown stains extending from the inside rim of the bowl to the water. The ESD lifted the lid of the water tank and the water was also colored a dark brown. The stained toilet was visible from the room's doorway. When asked about the appearance of the toilet, the ESD said the facility had been replacing toilets with rusted metal pipes, but this toilet had not yet been replaced. Later in the survey, the Administrator reported the toilet had been replaced.	F 253	**Other Residents** All resident rooms have the potential to be affected with stained toilets. The Environmental Services Director audited all resident rooms to ensure any toilets that were stained were either cleaned or replaced. **Facility System** In-Servicing will be completed by 3/11/16 for environmental services to ensure they are cleaning or replacing toilets that are severely stained. Education will also include daily cleanings of the toilets to prevent stain build-up. **Monitor** Starting on 3/4/16, the Environmental Services Director will audit weekly x 4, bi-weekly x 4, and then monthly x 3 resident restroom toilets to ensure there is no stain build-up, they are being cleaned, and replaced as necessary. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification. **Date of Compliance** March 11, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and interview, it was determined the facility failed to clarify duplicate physician orders and follow its own policy to assure accurate administration of medications for 1 of 9 residents (#18) of nine residents observed during the medication pass. This failure placed Resident #18 at risk for potential adverse effects from inadequate medication administration. Findings included: On 2/2/16 at 8:05 am LN #7 was observed administering one tablet of Vitamin D 1000 IU and one tablet of Vitamin D3 2000 IU. Record review of the resident's physician's orders revealed an order, dated 8/19/15, which instructed staff to administer Vitamin D3 2000 IU daily. An earlier order, dated 7/30/15, instructed staff to administer Vitamin D 1000 IU daily. Both orders remained on the current medication administration record for February 2016. On 2/2/16 at 9:25 am, when was asked if the 8/19/15 order had been clarified to determine whether the physician wanted both medications to continue, the DON reviewed the resident's clinical record and stated the order had not been clarified and offered to contact the physician. At 9:50 am, RN #4 stated the resident's physician had provided a clarification order instructing staff to discontinue the Vitamin D 1000 IU and continue	F 281	**F281 – Professional Standards** **Resident Specific** A clarification order was obtained from the physician to discontinue the Vitamin D 1000 IU and continue the Vitamin D3 2000 IU for resident #18. This is now accurately reflected in the Medication Administration Record (MAR). **Other Residents** All residents receiving medications have the potential to be affected. An audit of all residents receiving Vitamin D has been completed to ensure accurate physician orders are in place and reflected on the MAR. If any issues are found, the physician will be notified for clarification and then updated in the MAR. **Facility System** Licensed nurses will be in-serviced by 3/11/16 for medication administration to ensure Vitamin D is being dispensed per current physician orders. Education will	**3/11/16**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 21 the Vitamin D3 2000 IU. The facility's "Physician/Practitioner Orders" policy, dated September 2012, documented a clarification order was required for any orders that were "incomplete or raise questions." Resident #18 received doses of Vitamin D and Vitamin D3 from 8/19/15 to 2/2/16 before a clarification order was obtained on 2/2/16.	F 281	also include nurses' ensuring the MAR is being updated with current physician orders for accurate medication administration. **Monitor** Starting on 3/4/16, the care managers will audit physician orders and MAR's weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure they are up-to-date and accurate. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification. **Date of Compliance** March 11, 2016	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure a left gluteal pressure ulcer did not worsen from Stage II to Stage III or that physician orders were followed for a coccyx pressure ulcer. This was true for 1 of 2 sample residents (#4) reviewed for pressure ulcers. This failure resulted in harm when care plan interventions were not revised, and wound assessments and treatments were not consistently provided for Resident #4. Findings included:	F 314	**F314 – Pressure Sores** **Resident Specific** Resident #4's care plan interventions were revised, accurate wound assessments are being completed and documented, and consistent treatments are being provided. **Other Residents**	**3/11/16**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 314	Continued From page 22 Resident #4 was admitted to the facility on 12/22/15, and readmitted on 1/27/16, with multiple diagnoses, including pressure ulcers, status post fracture of left femur, and removal of a left hip internal fixation device. The Admission MDS, dated 12/29/15, documented the resident was cognitively intact, frequently incontinent of bowel, and required extensive assistance of 2 staff for mobility, transfers, and toileting. The resident's 12/22/15 Skin Integrity Care Plan documented pressure ulcers to the left and right gluteal folds. Interventions included an indwelling catheter, air mattress, pressure reducing chair device. Staff were directed to turn and reposition Resident #4 in bed every hour, check skin with cares, and complete wound assessments and treatments. Resident #4's Physician's Orders documented: 12/22/15 - Air mattress to bed and weekly skin check every Monday. 12/23/15 - Leave coccyx wound open to air, turn patient side to side while in bed. 1/4/16 - Apply Iodosorb gel to coccyx topically once daily every 3 days or prn. 1/4/16 - Cover the pressure ulcer with foam and change every 3 days or prn. a) The resident's Wound Data Collection assessments for the "left gluteal fold" [accurate anatomical location was left gluteal cleft] documented: *12/22/15 - Initial assessment, Stage II, measurements of 9.5 cm X 7 cm X 0.2 cm with area in center measuring 2 cm X 2 cm and "unstageable." No wound characteristics	F 314	All residents with pressure sores have the potential to be affected by this practice. An audit of all residents with pressure sores has been completed by the Director of Nursing and care managers to ensure appropriate care plan interventions; accurate wound assessments are being completed and documented; and consistent treatment is being provided. **Facility System** Licensed nurses will be in-serviced by 3/11/16 on revising care plan interventions, completing and documenting accurate wound assessments, and providing consistent treatment for residents with pressure sores. **Monitor** Starting on 3/11/16, the care managers will audit weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure residents with pressure sores have care plan interventions, accurate and documented wound assessments and consistent treatment. Audit results will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 314	Continued From page 23 documented, no drainage, and no dressing present. *12/28/15 - Stage II, measurements of 5 cm X 3.5 cm. No wound characteristics documented, no drainage, and no dressing present. *1/4/16 - Wound bed covered in 100% slough, periwound pink and free of infection, and no measurements. b) The resident's Wound Data Collection assessments for the "right gluteal fold" [accurate anatomical location was right gluteal cleft] documented: *12/22/15 - Initial assessment, measurements of 3.5 cm X 2 cm, wound bed 100% eschar, and no dressing present. *12/23/15 - Measurements of 2 cm X 2 cm, wound bed 50% slough, and no dressing present. *12/28/15 - Measurements of 3.5 cm X 2 cm X 0.2 cm, wound bed 25% slough, and no dressing present. *1/4/16 - Wound bed 100% slough, no measurements, and no dressing present. c) The resident's Wound Data Collection assessments for the "coccyx" [previously documented by the facility as the left and right gluteal fold. The accurate anatomical location was the resident's left and right gluteal cleft] documented: *1/5/16 - Wound bed completely covered with slough, no exudate, and no dressing. *1/6/16 - No dressing present, wound bed 50% slough, and minimum amount of purulent drainage. *1/7/16 - No dressing present and minimum amount of purulent drainage. *1/8/16 - No dressing present, and minimum amount of serosanguineous drainage. Treatment	F 314	reported to the monthly QAPI meeting for further monitoring and plan modification. **Date of Compliance** March 11, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 314	Continued From page 24 described as "open to air, turned every 2 hours..." *1/9/16 - No dressing present and no drainage. *1/10/16 - Appears white in color, dressing present and intact, and minimum amount of serous drainage. *1/11/16 - No dressing present and no drainage. *There were no measurements documented from 12/28/15 to 1/11/16. Resident #4's 12/23/15 Physician's progress notes contained no documentation regarding treatment or plan for pressure ulcers. The 1/4/16 Physician's progress note documented the resident had a foley catheter due to the coccygeal pressure sores and was admitted with two pressures ulcers. It described one ulcer as essentially healed and the other with some yellow slough, but the resident remained at high risk for further breakdown. The Physician on 1/4/16 ordered Iodosorb gel with a foam dressing applied and changed every 3 days and prn. Nurse Notes documented the following: -12/23/15 at 6:45 am: "...Unstagable [sic.unstageable] pressure ulcer to right gluteal fold opened, measures 2cm X 2cm. Left gluteal fold Stage 2 with unstagable area in it that is 3X2 [cm] remains red..." -12/24/15 at 12:58 pm: "...open area to coccyx open to air..." -12/25/15 at 6:37 pm: "...Open area noted to right gluteal fold...unstageable [sic.unstageable]wound noted to left gluteal fold..." -12/30/15 at 9:32 pm: "...Open areas noted to right and left gluteal fold, wound bed red no drainage noted..." -1/2/16 at 6:29 pm: "...open area noted to gluteal fold, has small amount of serous drainage, has yellow exudate with red in the center, no foul odor	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 314	Continued From page 25 noted..." -1/4/16 at 1:02 pm: "...wound to gluteal fold kept clean and dry and MD here to assess both wounds...turn every hour." -1/4/16 at 9:39 pm: "...Open areas noted to right and left gluteal fold, wound bed covered in slough..." -1/5/16 at 2:43 pm: "...Coccyx area has sloughy [sic.] area, moist and creamy in color..." -1/7/16 at 11:11 am: "...she continues with unstageable [ulcer] to coccyx and the stage 2 to her left gluteal fold has resolved..." On 2/1/16 at 5:00 pm, Resident #4's wound care was observed. LN #4 cleaned the coccyx pressure sore area, and applied Iodosorb Gel, with no dressing or measurements taken. LN #4 said the resident's measurements were taken every Wednesday and the dressing was discontinued. The coccyx area presented as a small denuded blister. The wound bed area was pink and healthy appearing tissue. On 2/2/16 at 5:00 pm, LN #4 said the resident's left gluteal fold pressure ulcer was assessed as a Stage II on admit and then worsened to a Stage III when it was noted to have 100% slough in the wound bed. LN #4 said the physician ordered the Iodosorb Gel and a foam dressing on 1/4/16, but the resident's plan of care was not revised when the wound worsened. On 2/3/16 at 10:00 am, the DON said nursing staff were not consistent on the resident's assessments, treatments, and documentation of the pressure ulcers and the facility was in the process of addressing these concerns.	F 314		
F 322	483.25(g)(2) NG TREATMENT/SERVICES -	F 322	**F322 – NG Treatment/Services**	**3/11/16**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 322 SS=D	Continued From page 26 RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to administer enteral feedings (liquid nutrition) and medications via a gastrostomy tube in a safe and dignified manner. This was true for 1of 3 residents (#5) sampled for PEG tubes. Findings included; On 2/1/16 at 12:20 pm, RN #1 was observed preparing medications and enteral feeding formula for administration to Resident #5, who was lying in bed. RN #1 crushed the following medications; calcium 500+D tablet, calcium	F 322	**Resident Specific** RN #1 was in-serviced on 2/8/16 regarding administering enteral feedings (liquid nutrition) and medications via a gastrostomy tube in a safe and dignified manner. Family's preference and physician's order were clarified and documented regarding the patting of resident #5's stomach to relieve air during tube feedings or medication administration. Care Plan was updated. **Other Residents** All residents with gastrostomy tubes receiving enteral feedings and medications via a gastrostomy tube have the potential to be affected. A complete audit of all residents with gastrostomy tubes was completed by the care managers. This audit was to ensure enteral feedings (liquid nutrition) and medications via a gastrostomy tube are being administered in a safe and dignified manner. **Facility System**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 322	Continued From page 27 carbonate 500mg antacid chewable tablet, and Tizanidine (a muscle relaxant) 2mg tablet. RN #1 then attached the feeding tube probe to the gastrostomy insert site on the resident's lower abdomen. After checking placement of the feeding tube with a 60 cubic centimeters (cc) syringe, RN #1 removed the piston from the syringe and stated, "We have to decompress the air from her stomach." RN #1 then began patting the resident's abdomen and said, "So much air," as air escaped from the stomach into the tube and out the syringe. RN #1 continued to pat the resident's abdomen and repeated, "So much air." RN #1 attempted to administer the crushed medication mixture into the syringe attached to the feeding tube probe by elevating the syringe, flushing the tube with water, and pouring the crushed medications mixed with water into the syringe. The crushed medication solution in the syringe did not flow by gravity into the tubing and RN #1 said, "We're stuck." RN #1 then replaced the piston into the syringe attached to the feeding tube probe and began to push the piston into the syringe to force the solution into the resident. The mixed medication solution did not flow into the tube and RN #1 continued to use force to push the solution into the tubing. RN #1 again said, "We're stuck," detached the syringe from the feeding tube probe, detached the feeding tube from the gastrostomy insert site and took the feeding tube probe to the bathroom. RN #1 turned the faucet on and placed the tip of the feeding tube probe under the flowing water. The surveyor observed that some of the crushed medication stuck in the tip of the probe went down the sink drain when rinsed under the faucet. RN #1 then re-attached the feeding tube probe to the gastrostomy insert site and attached the 60cc	F 322	Licensed nurses will be in-serviced by 3/11/16 to ensure enteral feedings (liquid nutrition) and medications via a gastrostomy tube are being administered in a safe and dignified manner, it is care-planned, and physician ordered. **Monitor** Starting on 3/4/16, the care managers will audit residents with gastrostomy tubes weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure enteral feedings (liquid nutrition) and medications via a gastrostomy tube are being administered in a safe and dignified manner, care planned, and physician ordered. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification. **Date of Compliance** March 11, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 322	Continued From page 28	F 322		

syringe without the piston. RN #1 poured the remaining medication mixture into the syringe, poured a can of enteral formula into the syringe, and stated she would call the doctor for an order for a liquid form of the medications.

The facility's policy and procedure for administering medications and feedings documented, "To administer tube feedings in a safe and appropriate manner, instill formula as ordered by physician. Give slowly and never use force. Prepare medication as appropriate. Use liquid form of medication whenever possible. Thick solutions can be mixed with sterile water if necessary. Check with pharmacy to see if medication is available in liquid form and whether tablets can be crushed. Administer medication with syringe slowly and steadily. Be careful that all medication in the med cup is administered to the resident."

On 2/1/16 at 12:30 pm, when asked why she patted the resident's abdomen during the procedure, RN #1 said, "I've always done it that way."

Physician orders, dated 2/1/16, did not include an intervention to pat the abdomen during gastrostomy feeding or medication administration. The physician order documented, "... use long probe for decompression, let gas in stomach escape before feeding."

The February 2016 care plan did not include direction to staff to pat the resident's abdomen to relieve air during tube feedings or medication administrations.

On 2/1/16 at 3:00 pm, the DON stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(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 322	Continued From page 29 resident's family member, upon admission to the facility, "taught" staff to pat Resident #5's abdomen. The DON said there was no physician order or care plan provision for the procedure, and no documentation that the family member taught the procedure to facility staff.	F 322		
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, record review, and interview, it was determined the facility failed to ensure the kitchen was maintained in a clean and sanitary manner; staff food products were stored separately from food stored for residents; and ensure routine safety and cleanliness checks were care planned for personal refridgerators in resident rooms. This had the potential to expose all residents consuming food stored and prepared in the facility's kitchen and 5 of 6 residents (#s 12, 19, 20, 21, & 22) with personal refrigerators to food-borne pathogens. Findings included: 1. On 2/1/16, the following was observed in the facility's kitchen:	F 371	**F371 – Food Service** **Resident Specific** The kitchen was cleaned and sanitized, replacement pans have been ordered to replace the "heavy build-up of grease" pans. The staff smoothie was discarded and staff member was educated immediately. Routine safety/cleanliness checks have been implemented and noted on the TAR for personal refrigerators in the rooms of residents #12, 19, 20, 21, and 22. Individualized care plans have been put in place for these residents. Temperature logs have been put in place for personal refrigerators in rooms for resident #s 19, 20, 21, and 22 rooms. Thermometers have been placed in the personal refrigerators for resident #s 19 and 20. **Other Residents**	**3/11/16**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 30 * Multiple pans with a heavy buildup of grease that had hardened and blackened the outer surfaces. * The exhaust fan at the back of the convection oven had a heavy buildup of dust and grease. The fan faced the cooking surface of the stainless steel griddle. * A refrigerator in the main food preparation area contained a 12 ounce plastic container with a lid. The container was not labeled or dated. During this observation, the DM said it was a fruit smoothie and that she would determine who made it and for which resident it had been made. * An uncovered ice scoop in a bracket on the wall to the right of the ice chest was open to air and, because the bracket was above the handwashing sink, exposed to potential splashing from the sink. * An opened and undated box of uncooked cereal. * Heavy build-up of bread crumbs on a toaster tray and grill. On 2/2/16 at 10:00 a.m. the DM stated the fruit smoothie observed earlier belonged to a dietary staff member who had placed the drink in the refrigerator beside foods stored for residents. 2. On 2/3/16 at 2:15 pm, with the ESS and ESD present, Resident #19's room was observed with a personal refrigerator. There was no thermometer observed in the refrigerator, no record to indicate the daily temperature was taken, no record of routine cleaning, and no record to show safe food storage was monitored. On 2/3/16 at 4:05 pm, with LN #4 and Resident	F 371	This practice had the potential to expose all residents consuming food stored and prepared in the facility's kitchen and for those residents who have personal refrigerators in their rooms. **Facility System** 1. Dietary staff will be in-serviced by 3/11/16 regarding kitchen cleanliness & sanitation, cleaning the equipment, cleaning schedules, and the storing of staff food separate from residents' food. a. New pans have been ordered to replace the pans with heavy build-up of grease that is hardened and blackened on the outer surface. b. The exhaust fan at the back of the convection oven has been cleaned and put on a cleaning schedule. c. Fruit smoothie from the staff member was discarded. d. A new ice scoop holder with lid has been ordered and installed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 31 #21 present, the resident's personal refrigerator was observed. LN #4 said the resident was responsible for monitoring the temperature and recording the information on a temperature log, which was located on the top of the refrigerator. The resident said she had a thermometer in the refrigerator and a daily temperature log, but did not remember the last time she checked the temperature. The temperature log record was dated 2014 and 2015 and did not contain any recorded temperatures nor any record for 2016. Resident #21 said she drank a container of milk from her refrigerator that morning and knew it was not spoiled because it was cold and tasted fine. The facility's May 2013 Policy and Procedure for resident's kitchen electrical appliances documented the resident/family would routinely clean the inside and outside of the appliance, a refrigerator was to have a thermometer, temperature of the refrigerator must be 41-degrees Fahrenheit or lower, the refridgerator was to be monitored to ensure acceptable temperatures, and all foods were to be labeled, dated and covered. The director of dietary services was required to care plan for routine checks for compliance with the family/resident expectations. Of the 6 residents with personal refrigerators, 5 of those refrigerators were identified with the following concerns: *Resident #s 12, 19, 20, 21 and 22 did not have information regarding the residents' responsibilities addressed in individual Care Plans and no facility documentation to reflect the refridgerators were routinely monitored and found in compliance;	F 371	e. The opened/undated box of uncooked cereal was discarded. f. Toaster and grill were thoroughly cleaned and placed on cleaning schedule. 2. Nursing, environmental services, and social services staff will be in-serviced by 3/11/16 regarding personal refrigerators in resident rooms and ensuring the refrigerators have thermometers, daily temperature logs, a routine cleaning schedule, and that the food is being stored safely (labeled, dated, & covered). Each resident/responsible party will be educated on the facility's policy and procedure for residents having personal refrigerators in his/her room. Care plans will be updated. **Monitor** Starting on 3/4/16, the Director of Dietary Services will audit weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure the kitchen is being cleaned and sanitized, equipment is clean, and staff food products are not being stored with resident food products. Starting on 3/4/16, Environmental Services Director will audit weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure personal refrigerators in resident rooms have thermometers, daily temperature logs, a routine cleaning schedule, and that the food is being stored safely (labeled, dated, &	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 32 *Resident #s 19, 20, 21, and 22 did not have a temperature log record in the room; and, *Resident #s 19 and 20 did not have a thermometer in the refrigerator.	F 371	covered). Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain complete and accurate medical records for each resident. This was true for 1 of 17 (#3) sampled residents and created the potential for decisions to be based on incomplete or inaccurate information, which increased the risk for complications due to inappropriate interventions. Findings included: Resident #3 was admitted to the facility on 5/23/03 with multiple diagnoses, including quadriplegia cerebral palsy, and intellectual disability.	F 514	**Date of Compliance** March 11, 2016 **F514** **Resident Specific** A letter was sent certified mail/return receipt to the family of Resident #3 asking for a copy of the Power of Attorney (POA) document to be maintained in the resident's medical record and another copy in the resident's business office file. If such document cannot be furnished by the family, then Social Services will work with the facility Ombudsman and court system to have guardianship established. **Other Residents** All residents with POA's have the potential to be affected. A complete audit of all residents with POA's will be completed by Social Services	**3/11/16**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135085	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOISE VILLAGE	3115 SYCAMORE DRIVE BOISE, ID 83703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 33 The resident's Cognitive Function/Impaired Thought Process Care Plan, dated 10/16/13, documented: * Discuss concerns with resident and problem solve with him; * Resident needs the assistance of either one of his 2 family members for complex decision making. The facility has identified one of these individuals as being Resident #3's POA; and, * Resident requires approaches which maximize his involvement in daily decision making and activity. The facility's February 2013 Policy on Legal Instruments documented: * If a person claims to have power of attorney, guardianship or conservatorship for a resident, the center must have a copy of the specific document and this should be retained in both the center medical record and the business office file for future reference. On 2/4/16, the DSS said Resident #3's POA was the primary contact for any medical and financial decision making since his 2003 admission, but the resident was able to make simple, daily decisions and make his needs known. The DSS said the facility should have a copy of the POA document in the resident's medical record, which staff were unable to locate.	F 514	to ensure POA documents are obtained and stored in the resident's medial record and business office file. **Facility System** Social Services staff will be in-serviced by 3/11/16 regarding POA documents and ensuring copies are retained in the resident's medical record and another copy in the resident's business office file. **Monitor** Starting on 3/11/16, the Social Services Director will audit weekly x4, bi-weekly x4, and monthly x3 to ensure POA documents are being obtained and stored in the resident's medical record and business office file. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification. **Date of Compliance** March 11, 2016	

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

February 24, 2016

Brian Davidson, Administrator
Good Samaritan Society - Boise Village
3115 Sycamore Drive
Boise, ID 83703-4129

Provider #: 135085

Dear Mr. Davidson:

On **February 5, 2016**, an unannounced on-site complaint survey was conducted at Good Samaritan Society - Boise Village. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from February 1, 2016 to February 5, 2016.

Call light response times were observed during survey. Nursing care and staff interactions were observed with fourteen residents, including the identified resident.

The medical record of the identified resident and thirteen other residents were reviewed for quality of care and life concerns. The facility's grievance file and Incident and Accident reports for January 1, 2015 to February 1, 2016 were reviewed. Staffing numbers and hours were reviewed for January 10, 2016 to January 31, 2016. The Resident Council minutes from November 2015 to January 2016 were reviewed.

The identified resident, four other individual residents, twelve residents in the Resident Group meeting, three residents' family members, including the identified resident's family member, were interviewed about quality of care and quality of life concerns. The Director of Social Services and Ombudsman were interviewed about quality of care, quality of life, and resident rights.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007025

Allegation #1:

An identified resident was left soiled for two hours.

Findings:

Call light response times were observed to be appropriate during the survey process. The identified resident was able to activate the call light and make his/her needs known. The resident was observed while staff provided care and interacted with him/her. The staff were aware of the resident's limitations and handled these appropriately.

The identified resident, four other individual residents, and twelve residents in the Resident Group meeting were interviewed and voiced no concerns regarding assistance with toileting or incontinence. There were no residents observed with incontinent cares not being met during survey.

The resident's medical record was reviewed for quality of care concerns and did not reveal any areas that had not been handled appropriately by the facility. Resident Council meeting minutes and grievances did not document issues with toileting/incontinence concerns. The Incident and Accident reports including the investigation, corrective actions, and interventions were reviewed for toileting/incontinent needs and found to be appropriate and in compliance. Staffing numbers and hours were reviewed for January 10, 2016 to January 31, 2016 and were determined as appropriate for regulatory standards.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #2:

An identified resident's visitors were asked to leave and were not allowed to visit.

Findings #2:

The identified resident and other residents were observed during the survey when staff, visitors, and residents were interacting with one another and there were no identified concerns.

The medical record of the resident was reviewed and the resident was determined vulnerable and at risk for exploitation. The resident was allowed visitors in private settings and had his/her personal cell phone available for use.

Long Term Care facilities have federal regulatory guidance that instructs facilities of the right to impose "reasonable restrictions" for resident access and visitation rights The facilities have the

responsibility to protect the security of all the facility's residents and can deny access or provide limited and supervised access to a visitor if that individual has been found to be abusing, exploiting, or coercing a resident; deny access to visitors who have been committing criminal acts such as theft; or deny access to visitors who are inebriated and disruptive.

This allegation was not substantiated based on the supporting evidence provided.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #3:

An identified resident's conversations are being recorded.

Findings #3:

The identified resident and other residents were observed in the facility during the survey and there were no noted conversations being recorded. There was no recording system observed during the survey.

Resident Council meeting minutes, grievances, and Incident and Accident reports mentioned no information about residents' conversations being recorded.

The identified resident and thirteen other residents' medical records did not reflect any personal resident conversations being recorded.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #4:

There is no one at the facility who cares about an identified resident.

Findings #4:

The identified resident and thirteen other residents were observed during nursing care and staff interactions during the survey. The staff and resident interactions and cares were appropriate and demonstrated in a caring manner.

The identified resident, four other individual residents, and twelve residents in the Resident Group

meeting were interviewed and pleased in calling the facility their home. The identified resident was comfortable and felt safe in his/her room and common areas of the facility.

The identified resident's medical record was reviewed for quality of care concerns and did not reveal any areas that had not been addressed appropriately by the facility. The facility's grievance file and Incident and Accident reports were reviewed for quality of care and life concerns. The identified resident's concerns were appropriately investigated, corrective actions and interventions implemented.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #5:

An identified resident's guardian will not allow a transfer to another facility.

Findings #5:

The identified resident, four other individual residents, and twelve residents in the Resident Group meeting were interviewed and voiced no concerns/desire in transfers to other facilities.

The medical record of the identified resident was reviewed for quality of care concerns and did not reveal any areas that were not addressed appropriately. The resident had family members and staff, including Social Services and the Ombudsman, actively involved with the resident's best interest and safety in mind.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

D. Scott

David Scott, R.N., Supervisor
Long Term Care

DS/lj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

March 22, 2016

Brian Davidson, Administrator
Good Samaritan Society-- Boise Village
3115 Sycamore Drive
Boise, ID 83703-4129

Provider #: 135085

Dear Mr. Davidson:

On **February 5, 2016**, an unannounced on-site complaint survey was conducted at Good Samaritan Society - Boise Village. The complaint was investigated in conjunction with the on-site Federal Recertification, Complaint Investigation, and State Licensure survey conducted February 1, 2016 through February 5, 2016.

Call light placement and staff responses to call lights were observed throughout the survey as were the provision of care and staff interactions with fourteen residents, including the identified resident. In addition, six nurses were observed as they administered medications to nine residents.

The medical records of the identified resident and thirteen other residents were reviewed for quality of care and quality of life issues. The facility's grievance files and Incident and Accident reports for January 1, 2015 to February 1, 2016, abuse allegation investigations, and Resident Council minutes for November 2015 to January 2016, were also reviewed.

Interviews about quality of life and quality of care were conducted with five individual residents, twelve residents in a Resident Group meeting, and three resident representatives, including the identified resident's representative. Interviews about quality of care, quality of life, and resident rights, were also conducted with licensed nurses, the Administrator, the Director of Social Services, and the Ombudsman.

The complaint allegation, findings and conclusions are as follows:

Complaint#ID00007138

ALLEGATION #1:

A nurse medicated the identified resident with Ativan on August 6, 2015 to avoid having to respond to his/her call light.

FINDINGS:

Based on observations and record reviews, no concerns or issues that a nurse medicated the identified resident, or any resident, to avoid having to respond to their call light were identified. In addition, during interviews with residents, resident representatives, including the identified resident's representative, and staff, no concerns or issues were expressed that a nurse, or any staff, medicated the identified resident, or any resident, to avoid having to respond to the call light. Therefore, it was determined that the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Ativan has "never" been used to treat the identified resident's seizure activity prior to August 6, 2015.

FINDINGS:

The identified resident's clinical record documented Ativan was ordered in June 2015. In addition, the resident's representative said the physician had used both Ativan and a muscle relaxant in the past to address the seizure activity.

Based on observations, record reviews, and interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

A nurse "silences" call lights to avoid responding to them.

FINDINGS:

The identified resident's representative said a family member was with the resident almost every day. The representative denied concerns that a nurse, or any staff, silenced the resident's call lights.

Based on observations, including call lights, interviews with residents, other resident representatives, and staff, and record reviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

D. L. Scott

David Scott, R.N., Supervisor
Long Term Care

DS/lj