



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
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3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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November 17, 2016

Julie Johansen, Administrator  
Good Samaritan Society - Silver Wood Village  
PO Box 358  
Silverton, ID 83867

Provider #: 135058

Dear Ms. Johansen:

On **October 26, 2016**, we conducted an on-site revisit to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of . However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- F0157 -- S/S: D -- 483.10(b)(11) -- Notify Of Changes (injury/decline/room, Etc)**
- F0309 -- S/S: G -- 483.25 -- Provide Care/services For Highest Well Being**
- F0323 -- S/S: D -- 483.25(h) -- Free Of Accident Hazards/supervision/devices**
- F0329 -- S/S: E -- 483.25(l) -- Drug Regimen Is Free From Unnecessary Drugs**

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.) **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 **November 28, 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.
- 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*.

The findings of non-compliance on **October 26, 2016**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On October 4, 2016, CMS notified the facility of the intent to impose the following remedies:

- DPNA 90 days after June 24, 2016

**Federal Civil Money Penalty of \$2,503.00 per day beginning June 24, 2016 and continuing until the facility is in substantial compliance or the provider agreement has been terminated.**

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

Julie Johansen, Administrator  
November 17, 2016  
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If you believe the 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, 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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 **November 28, 2016**. If your request for informal dispute resolution is received after **November 28, 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,



Nina Sanderson, L.S.W., Supervisor  
Long Term Care

NS/lj

Julie Johansen, Administrator  
November 17, 2016  
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/01/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/26/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 WEST SEVENTH STREET</b> <b>SILVERTON, ID 83867</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS  An on-site revisit survey was conducted at the facility from October 25, 2016 to October 26, 2016.  The surveyors conducting the survey were:  Presie C. Billington, RN, Team Coordinator Marci Clare, RN David Scott, RN Jenny Walker, RN  Definitions Include:  AM or am = Morning CNA = Certified Nursing Assistant GDR = Gradual Dose Reduction DNS = Director of Nursing Services DON = Director of Nursing MAR = Medication Administration Record MDS = Minimum Data Set mg = Milligram MH = Mental Health SSD = Social Services Designee SW = Social Worker WC = Wheelchair	{F 000}			
{F 157} SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or	{F 157}		12/7/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/25/2016

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.

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{F 157}	<p>Continued From page 1</p> <p>psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure physicians were notified of significant change in residents' clinical conditions. This was true for 2 of 8 (#1 and #8) residents sampled for family and physician notification. This deficient practice created the potential for harm a) when the physician was not notified of Resident #1's bowel impaction, and b) when Resident #8's physician was not notified of her statements of suicide and wanting to be dead. Findings include:</p>	{F 157}	<p>F157 D</p> <p>1. Resident # 1's MD has been notified of her bowel impaction on 10/25/2016. Resident # 2's MD has been notified of suicidal statements on 10/26/2016.</p> <p>2. All residents with a bowel impaction have the potential to be effected by this practice. All residents have been assessed and interventions implemented. Any residents expressing suicidal ideation have the potential to be affected by this practice. These residents have been assessed and interventions implemented.</p>		

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{F 157}	<p>Continued From page 2</p> <p>1. Resident #8 was admitted to the facility on 1/28/16, with multiple diagnoses, including lung cancer and altered mental status.</p> <p>Resident #8's Significant Change of Condition MDS assessment, dated 8/24/16 documented she had a diagnosis of cancer, had no thoughts of hurting herself, and received hospice services.</p> <p>Resident #8's nurses' notes, dated 8/10/16, documented Resident #8's physician informed her she had 6 months or less to live and a referral was made for hospice care.</p> <p>On 10/25/16 at 11:25 am, Resident #8 said she had hypertension, diabetes and was told by her doctor she had 6 months to live. Resident #8 also said, "I am depressed all the time, I shall commit suicide to be with my husband." When asked if she had discussed her thoughts with the staff, Resident #8 said she used to be on a suicide watch. As Resident #8 was talking to the surveyor, the LSW entered the room and spoke to her.</p> <p>A 10/25/16 nurses' note documented Resident #8 was interviewed regarding her suicidal statements made to the surveyor that morning. The note documented Resident #8 said, "I just think about being dead and being with my husband again. I am not going to kill myself. I sometimes wish it was just over. I get a little carried away when I am feeling sorry for myself."</p> <p>On 10/26/16 at 9:55 am, the LSW said Resident #8 was placed on every 15 minute checks and an appointment was made for her to see her Mental Health Counselor. The LSW also said Resident</p>	{F 157}	<p>3. The QAPI process identified the root cause of the deficiency as "failure to notify physician." Bowel alerts for no BM will be monitored daily by the Charge Nurse using the PCC Dashboard. Which; identifies residents not having a bowel movement in two or more days. Action will be taken as the concern is identified. The Doctor will be notified, to ensure the resident receives timely bowel care according to Doctors orders. For any resident making statements of suicidal ideation the Doctor will be notified and orders received for further follow-up. Licensed Nurses will be in serviced on physician notification of suicide statements at licensed staff meeting 11/29/16.</p> <p>Nurses reeducated on 11/29/2016. Nurses are to pull up the dashboard at the beginning of each shift and address any lack of BMs that are mentioned on the resident. Also, any suicidal statements are to be charted and go to the 24 hour report, doctor is to be notified, Clinical follow up committee, reviews. The Dashboard and 24- hour report documentation 5 days a week and ensures that follow up has happened.</p> <p>4. The DNS or designee will audit to ensure Residents who have had an impaction have had their MD notified. Audits completed weekly x 4, Bi-monthly x 2, and quarterly X3. All audit results will</p>	

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{F 157}	<p>Continued From page 3</p> <p>#8's daughter was notified of her current condition.</p> <p>On 10/26/16, the DON said Resident #8 was on every 15 minute checks and the CNA would also do a visual check of her room. When asked, the DON said the physician had not been notified of Resident #8's statements about suicide and wanting to be dead. The DON said she would notify the physician and would make another call to Resident #8's daughter.</p> <p>2. Resident #1 was admitted to the facility on 12/11/15, with multiple diagnoses which included depression, weakness, constipation, obesity, osteoarthritis and pain.</p> <p>The quarterly MDS assessment, dated 8/20/16, documented Resident #1 was incontinent of bowel and bladder at all times.</p> <p>Resident #1's Physician Orders, dated 12/11/15, included Milk of Magnesia Concentrate Suspension, as needed for daily for constipation.</p> <p>Resident #1's care plan, dated 8/25/16, documented she was to have at least one bowel movement every 3 days. Staff were to check Resident #1's incontinent brief every 2 hours; observe, monitor, and report to the physician any signs, symptoms or complications related to constipation.</p> <p>A bowel assessment, dated 12/22/15, documented staff were to assist Resident #1 to increase her amount of exercise or activity.</p> <p>Resident #1's bowel monitor form documented</p>	{F 157}	<p>be reported to QAPI for additional monitoring/modification.</p> <p>The Administrator or designee will audit to ensure Residents who have made suicidal statements have had their MD notified. Audits will be completed weekly x 4, Bi-monthly x 2, and monthly x 3. All audit results will be reported to QAPI for additional monitoring/modification.</p> <p>5. Compliance will be on or before 12/07/2016</p>		

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{F 157}	Continued From page 4 no bowel movement from 10/12-15/16, 10/17-18/16, 10/21/16, and 10/23-25/16.  The facility's Bowel Assessment Procedure documented, "Prevention of constipation and fecal impaction is critical..." and defined fecal impaction as "a large mass of dry, hard stool that can develop in the rectum due to chronic constipation. This mass may be so hard that the resident is unable to move it from the rectum."  Nurses' Notes, dated 10/22/16, documented Resident #1 "...was impacted this afternoon. It was necessary to digitally remove the stool in order to facilitate a BM. The consistency of her stool was very hard, and very dry. A sand like consistency."  Nurses' Notes, dated 10/22-25/16, did not include documentation that the family or the physician were notified of the impaction.  On 10/25/16 at 3:45 pm, the DNS stated that she would have expected the nurses to notify the physician of Resident #1's impaction as he was making rounds and that she did not see documentation in the progress notes that this was done.	{F 157}			
{F 309} SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	{F 309}		12/7/16	

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{F 309}	Continued From page 5  This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, it was determined the facility failed to ensure physician orders were followed and a resident who received dialysis had a care plan for handling emergencies. This was true for 2 of 2 sampled residents (#1 and #2). As a result, a) Resident #1 was harmed when he did not receive his bowel medications as ordered and had fecal impaction, and 2) Resident #2 had the potential for harm when his care plan did not include how to handle emergencies, such as bleeding from his AV fistula. Findings include:  1. Resident #1 was admitted to the facility on 12/11/15, with multiple diagnoses including constipation, pain, depression, obesity, and weakness.  Resident #1's quarterly MDS assessment, dated 8/20/16, documented she was incontinent of bowel and bladder at all times.  Resident #1's Physician Orders, dated 12/11/15, included Milk of Magnesia Concentrate Suspension, 30 ml by mouth as needed daily for constipation, and standing orders for Senna, Dulcolax, Milk of Magnesia, and Fleet Enema [medications for constipation].  Physician Orders, dated 8/1/16, included Effexor XR capsule for major depression. Resident #1's antidepressant medication care plan documented potential adverse effects included constipation.	{F 309}	F309 1. Resident # 1 has had additional interventions, including nutrition and hydration implemented to the resident's MAR and care plan to prevent impaction on 11/25/2016. Resident # 2 has had interventions care planned for emergency care of AV fistula on 11/25/2016. MD orders received to give Medications after resident returns from dialysis. 2. Residents with impactions have the potential to be affected by this practice. Residents with similar issues have been identified and the concern corrected. Residents with AV fistulas have the potential to be affected by this practice. Residents with similar issues have been identified and the concern has been corrected. Residents receiving dialysis have the potential to be affected by this practice. Residents with similar issues have been identified and		

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{F 309}	<p>Continued From page 6</p> <p>Resident #1's care plan, dated 8/25/16, documented she was to have at least one normal bowel movement every 3 days. Interventions documented staff were to check Resident #1's incontinent brief every 2 hours, and observe, monitor, and report to the health care provider, any signs and symptoms of complications related to constipation.</p> <p>Resident #1's Bowel Monitor flowsheet documented no bowel movements from 10/12-15/16, 10/17-18/16, 10/21/16, and 10/23-25/16.</p> <p>The facility's Bowel Assessment Procedure documented "Prevention of constipation and fecal impaction is critical..." and defined fecal impaction as "a large mass of dry, hard stool that can develop in the rectum due to chronic constipation. This mass may be so hard that the resident is unable to move it from the rectum."</p> <p>Nurses' Notes, dated 10/22/16, documented Resident #1 "...was impacted this afternoon. It was necessary to digitally remove the stool in order to facilitate a BM. The consistency of her stool was very hard, and very dry. A sand like consistency."</p> <p>Nurses' Notes, dated 10/22-25/16, did not include documentation the bowel medications were administered.</p> <p>Resident #1's medication administration record for the month of October 2016, did not include documentation that PRN medications were given for constipation.</p>	{F 309}	<p>corrected.</p> <p>3.The QAPI process identified the root cause of the impaction as lack of review of bowel movement data daily and no admission order for emergency care of fistula. Process change will be daily review of bowel data by the DNS or designee. Any resident with an AV fistula will be reviewed on admission and emergency interventions and when medications should be administered will be care planned. Bowels and AV fistula care are reviewed at clinical follow up meeting which meets five days a week. Nursing staff will be reeducated on daily review of bowel data, and implementation of procedures including emergency AV fistula care at nurses meeting 11/29/16.</p> <p>4.The DNS or designee will audit bowel data and interventions. Audits will be completed weekly x 4, bi-monthly x 2, and quarterly X 3.</p> <p>Audit results will be reported to QAPI for additional monitoring and modification. The DNS or designee will audit admission orders for emergency care interventions of AV fistulas. Audits will be completed</p>		

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{F 309}	<p>Continued From page 7</p> <p>On 10/25/16 at 3:45 pm, the DNS stated that they had standing physician orders for bowel medications, and their dosages, to prevent constipation, but those orders do not indicate when to give the bowel medications.</p> <p>Resident #1's bowel medication orders were not clarified with the physician to identify when they were to be given and in what order. Additionally, the frequency of Resident #1's bowel movements was not effectively monitored, and bowel medications administered, to promote a bowel movement every 3 days.</p> <p>2. Resident #2 was admitted to the facility on 10/24/16, with multiple diagnoses, including end stage renal disease, and he received dialysis.</p> <p>Resident #2's recapitulated September and October 2016 physicians' orders, and MAR, documented staff were to monitor his dialysis fistula insertion site BID for bruit present, bleeding, and S/S of infection and drainage, and to report these to the MD/dialysis unit, as indicated.</p> <p>Resident #2's Hemodialysis care plan, revised 8/25/16, documented he received hemodialysis each morning on Monday, Wednesday and Friday, interventions included:</p> <ul style="list-style-type: none"> <li>* Monitor and document for peripheral edema</li> <li>* Do not use the left arm for blood draws</li> <li>* Do not take blood pressure on the left arm</li> <li>* Monitor/document/report to health care provider PRN for s/s of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds,</li> </ul>	{F 309}	<p>weekly x 4, bi-monthly x 2, and quarterly X 3. Audit results will be reported to QAPI for additional monitoring/modification.</p> <p>5.Compliance will be on or before 12/7/16.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/26/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 WEST SEVENTH STREET SILVERTON, ID 83867</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 309}	Continued From page 8 any signs and symptoms of infection to access site: redness, swelling, warmth or drainage. *Monitor/document BID or the MAR the status of the dialysis fistula for bruit, bleeding, s/s of infection or redness and report to MD, dialysis unit.  Resident #2's Hemodialysis care plan did not address how to handle emergencies and complications such as bleeding from the access site. The care plan also did not address when to give Resident #8's medications on the days he received dialysis.  On 10/26/16 at 2:20 pm, LN #1 was asked about Resident #2's medications. The LN said staff gave Resident #2 his medications early on those days before he left to go to the dialysis facility. When asked about handling an emergency such as bleeding of Resident #2's AV fistula site, LN #1 said she would apply pressure on the site and call the physician, when needed. When asked, LN #1 said Resident #2 did not have a care plan for handling emergencies, such as bleeding from his fistula site.	{F 309}			
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced	{F 323}		12/7/16	

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{F 323}	<p>Continued From page 9</p> <p>by:</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents at risk of falling were provided adequate supervision to avoid accidents. This was true for 1 of 5 sampled residents (#4) reviewed for falls and created the potential for more than minimal harm if Resident #4 received an injury requiring invasive procedures related to repeated falls in the facility. Findings include:</p> <p>Resident #4 was admitted to the facility on 7/31/11, with diagnoses of cerebral infarction, osteoarthritis, schizophrenia, behavioral disturbances, and extrapyramidal syndrome.</p> <p>The 10/3/16 quarterly MDS assessment documented Resident #4 had experienced 2 falls since the previous quarterly MDS assessment of 7/15/16, and required the assistance of at least one staff for surface-to-surface transfers due to unsteadiness.</p> <p>Falls Tools (assessments), dated 8/8/16, 8/17/16, 9/20/16, 10/10/16, and 10/15/16, documented Resident #4 was at "high risk" for falls.</p> <p>Incident and Accident Reports documented Resident #4 experienced non-injury falls at the facility on 8/17/16, 9/19/16, 9/20/16, 10/10/16, and 10/15/16.</p> <p>Interventions documented on the Incident and Accident Reports for Resident #4 documented the following interventions:</p> <p>* 8/17/16 - Medication changes to improve sleep; 1:1 supervision following the fall; increase in</p>	{F 323}	<p>F323</p> <p>1.Resident # 4-falls were reevaluated and Resident's more active and energetic times on 11/25/16. Care plan interventions were created to provide supervision and meet Resident needs during those times.</p> <p>2.Residents with a history of repeated falls have the potential to be affected by this practice. These residents have been reviewed and care plan Interventions have been updated to reflect individualized Care.</p> <p>3.The QAPI process identified the root cause as the lack of interventions for more active and energetic times. As Residents needs change, Residents will be reassessed for individual interventions related to activity or program interventions. Staff will be in serviced on resident #4's additional activity interventions at the staff meeting 11/29/2016.</p> <p>4.The DNS or designee will audit Resident #4 activity interventions weekly x 4, Bi-monthly x 2, quarterly x 3. Audit information will be forwarded to QAPI for monitoring/modification.</p> <p>5.Compliance will be on or before</p>		

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{F 323}	<p>Continued From page 10</p> <p>antipsychotic medication at bedtime.</p> <ul style="list-style-type: none"> <li>* 9/9/16 - Resident to remain in line-of-sight supervision; continue with activities of interest; continue with all current interventions.</li> <li>* 9/20/16 - Continue with all interventions; continue to assess medication changes.</li> <li>* 10/10/16 - Distract with building blocks; allow resident to do as he wants, but ensure resident is safe; continue with current interventions.</li> <li>* 10/15/16 - Provide food and fluids; line-of-sight supervision; provide activity in day room after meals; create safety awards for resident; continue with current interventions.</li> </ul> <p>Resident #4's falls care plan documented he was at risk for falls related to cognitive deficits, incontinence, medication side effects, unsteady gait, recurrent falls (27 falls were identified at the time of the facility's June 2016 recertification survey), poor safety awareness, and impulsiveness. The care plan included a goal of ensuring Resident #4 would not experience any falls by 1/2/17, and documented staff would provide the following interventions:</p> <ul style="list-style-type: none"> <li>* Encourage activities that promoted strengthening and improved mobility (10/13/16)</li> <li>* Provide "appropriate" footwear (7/28/16)</li> <li>* Provide a cushion to "help prevent sliding out" of the wheelchair (8/8/16)</li> <li>* Monitor for significant changes in gait, mobility, standing/sitting balance, and lower extremity joint function (7/28/16)</li> <li>* Provide diversion and distraction (10/13/16)</li> <li>* Offer to transfer to a couch or easy chair after meals (10/13/16)</li> <li>* Provide restorative nursing services (8/9/16)</li> <li>* Ensure correct bed height and arrange the</li> </ul>	{F 323}	12/07/2016.		

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{F 323}	<p>Continued From page 11</p> <p>resident's room to promote safety (10/5/16)</p> <ul style="list-style-type: none"> <li>* Ensure a stuffed animal and call light were accessible (5/23/16)</li> <li>* Review bowel/bladder continence status (10/5/16)</li> <li>* Review medical conditions that predisposed the resident to falls or increased the risk of injury from falls (10/5/16)</li> <li>* "Monitor resident every 15 minutes for high fall risk ..." (5/4/16)</li> </ul> <p>Resident #4's Nurses' Notes documented the following:</p> <ul style="list-style-type: none"> <li>* 8/13/16 - 12:57 am: "Got up and was found in the bathroom of his room. Staff 1:1 [one-to-one supervision] at this time for patient's safety."</li> <li>* 8/13/16 - 4:14 am: "... gotten [sic] up by self again."</li> <li>* 8/17/20 - 3:38 am: "He continually attempts to self transfer ... He is requiring 1:1 supervision."</li> <li>* 8/17/16 - 2:32 pm: "Resident was found sitting on the floor. He continues to fall and has had [more than] 25 falls in the past 6 months ... requires 1:1 interventions when not when [sic] highly agitated."</li> <li>* 8/31/16 - 10:08 am: "He is currently in need of 1:1 in order to prevent falls as he is sitting in his room and tends to try to transfer from his WC to his recliner or his bed."</li> <li>* 9/3/16 - 4:02 pm: "... then he pulled himself up by the fireplace grill. Took hree [sic] of us to move the [sic] W/C and have him sit down ... told the CNAs on that they need to be one-on-one with him t/o [throughout] the shift. The staff will take turns, will attempt to find a staff member to sit with him this shift and if [anti-anxiety medication] not effective, find someone over the night shift."</li> </ul>	{F 323}			

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{F 323}	<p>Continued From page 12</p> <p>* 9/20/16 - 3:47 pm: "Resident had a non-injury fall this morning at 11:40 [am]. It appeared that he was attempting to self transfer to the couch from his WC."</p> <p>* 9/21/16 - 12:11 am: "Resident awake and attempting to get out of bed."</p> <p>* 9/23/16 - 9:53 pm: "He did continue to try to move about the room and self transfer to other furniture, but ... assigned a 1:1 so that he could be monitored in order to prevent self harm/fall."</p> <p>* 9/25/16 - 2:48 pm: "Resident self transferred to wheelchair unassisted and unwitnessed in his room. CNA doesn't not [sic] know where the wheelchair was located in his room when he transferred."</p> <p>* 10/7/16 - 9:28 am: "... continues to be a very high risk for recurrent falls due to very poor safety awareness and impulsiveness, so he remains on [every] 15 minute checks ..."</p> <p>* 10/15/16 - 8:13 am: "Resident had a non-injury fall this AM attempting to self transfer from WC to a rocking chair in the dayroom."</p> <p>On 10/25/16 at 10:45 am, Resident #4 was observed sitting in his wheelchair in the dayroom as one staff member assisted another resident. At 10:50 am, that staff member left the dayroom and the residents, including Resident #4, unattended until 10:58 am, when another staff member entered the dayroom. A male and female staff member positioned in the glass-enclosed nurses' station did not look up from their work during this observation.</p> <p>On 10/26/16 at 12:30 pm, Resident #4 was brought into the day room, where he was taken to a table and provided with "Lincoln Logs," which he handled for approximately 1 minute.</p>	{F 323}			

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{F 323}	Continued From page 13 The resident was not provided line-of-sight staff supervision until 12:33 pm. At 1:57 pm, Resident #4 was observed in the day room as he self-transferred from a couch to a wheelchair. The wheelchair did not have the brakes engaged and moved approximately two-to-three inches backward as he transferred. Three staff in the day room at the time of this observation had their backs to Resident #4 and did not witness the self-transfer.	{F 323}			
{F 329} SS=E	On 10/26/16 at 2:00 pm, the DON stated 1:1 supervision was identified as an intervention following Resident #4's 9/9/16 fall, but was not included on the falls care plan. The DON stated "line-of-sight" supervision could apply to any staff member, who were not required to document this level of supervision. The clinical record did not include documentation that 1:1 supervision was provided to Resident #4. <b>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b>  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	{F 329}		12/7/16	

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{F 329}	<p>Continued From page 14</p> <p>as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to ensure residents did not receive duplicative antipsychotic medications and that those receiving psychotropic medications were adequately monitored for targeted behaviors. This was true for 5 to 5 residents sampled for psychotropic medications (#1, #8, #10, #14, and #15) and had the potential for more than minimal harm should medications not have their desired effect, lead to adverse consequences, or if residents received excessive dosages over prolonged periods of time. Findings include:</p> <p>1. Resident #15 was admitted to the facility on 5/23/16, with diagnoses that included dementia with behavioral disturbances, restlessness, and agitation.</p> <p>The 8/11/16 quarterly MDS assessment documented Resident #15 had little interest or pleasure in her everyday life; felt down, depressed, and/or tired; had trouble concentrating; wandered; often rejected cares; and displayed verbally/physically abusive</p>	{F 329}	<p>F329 E</p> <p>1. Resident # 1, 8, 10, 14 and 15 now have every shift behavior monitoring with their medication administration records.</p> <p>2. Resident's receiving psychotropic medications have the potential to be affected. Residents have been reviewed and every shift Behavior Documentation has been Implemented.</p> <p>3. Licensed staff and LSW will be educated on every shift behavior documentation 11/29/16.</p> <p>4. Behavior documentation audits will be completed weekly x 4, bi-monthly x 2 and quarterly x 3 by the SSD or designee. Information will be forwarded to QAPI for additional monitoring/modification.</p> <p>5. Compliance will be on or before 12/07/2016.</p>		

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{F 329}	<p>Continued From page 15 behaviors including hitting and slapping others; and wandered the facility.</p> <p>Recapitulated Physician Orders for October 2016, documented Resident #15 was to receive the following medications for dementia with behavioral disturbance:</p> <ul style="list-style-type: none"> <li>* Namenda 10 mg twice daily - started 5/23/16</li> <li>* Aricept 10 mg daily - started 5/24/16</li> <li>* Zyprexa 5 mg daily - started 8/17/16</li> </ul> <p>Resident #15's antipsychotic medication care plan documented the resident experienced dementia with behavioral disturbances as evidenced by restlessness and agitation. Interventions included:</p> <ul style="list-style-type: none"> <li>* Monitor for side effects of sedation, orthostatic hypotension, dry mouth, constipation, and somnolence.</li> <li>* Observe for clinical worsening of depression and risk of suicide, agitation, anxiety, and increased cholersterol, constipation, dizziness, and/or drowsiness.</li> </ul> <p>August 2016 MARs documented Resident #15 received Aricept as ordered from August 2016 through 10/25/16. Behavioral monitoring forms for the same timeframe were blank where staff were to document the resident's behaviors and monitoring of the medications' potential side effects.</p> <p>Nurses' Notes from August 2016 through October 2016, documented only the following in regards to the care-planned observations/monitoring:</p>	{F 329}		

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{F 329}	<p>Continued From page 16</p> <p>* 9/11/16: "She hit staff 3 times in the arm ..."</p> <p>* 10/8/16: "... had increased behaviors throughout the day. She was agitated and angry when redirected."</p> <p>* 10/8/16: "... was angry and combative towards a CNA this morning after breakfast ... at this point [Resident #15] took her walker and shoved it into the CNA."</p> <p>* 10/10/16: "Current Zyprexa dose is 5 mg/day. May require dose adjustments."</p> <p>* 10/14/16: "[Resident #15] has been sleeping in her chair with SSD has been into visit, this morning [she] was sleeping in her bed. SSD was informed [Resident #15] has had a change in behaviors."</p> <p>On 10/26/16 at 2:00 pm, the DON stated she did not know the reason Resident #15 was ordered three different psychotropic medications for the same diagnosis of dementia with behavioral disturbances. When shown the blank observation/monitoring forms, the DON stated, "The care plan says [monitoring of behaviors and the medications' potential adverse side effects] is to be done so no documentation means it was monitored and no behaviors took place."</p> <p>2. Resident #8 was admitted to the facility on 1/28/16, with multiple diagnoses, including lung cancer and persistent mood disorder.</p> <p>Resident #8's Quarterly MDS assessment, dated 7/2/16, documented the following:</p> <p>*No signs of hallucinations or delusions *Verbal behaviors directed toward others (e.g., threatening others, screaming at others, cursing at others)- behavior of this type occurred 1-3</p>	{F 329}			

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{F 329}	<p>Continued From page 17</p> <p>days</p> <p>*Little interest or pleasure in doing things and feeling tired or having little energy- nearly every day</p> <p>Resident #8's October 2016 recapitulated physicians' orders included Depakote tablet delayed release 125 mg for dementia without behavioral disturbance and Fluoxetine capsule 40 mg for depression, both of which were to be given once a day.</p> <p>Resident #8's Behavior Care Plan documented the following interventions:</p> <p>*Increase communication between resident/family about care and living environment. Explain all procedures and treatments, medications, results of labs/test...</p> <p>*Discuss resident's feelings relative to disease process weekly with one on one visits with SSD.</p> <p>*Provide assistance/supervision/support with identification of potential solutions to present problems.</p> <p>*Attempt non-pharmacological interventions: 1:1 visit with SSD and Mental Health supports, offer hot cocoa...</p> <p>*Initiate a weekly visit with a friendly resident for support and socialization.</p> <p>Resident #8's nurses' notes documented the following:</p> <p>*8/10/16 at 3:45 pm, Resident #8 returned from</p>	{F 329}		

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{F 329}	<p>Continued From page 18</p> <p>her doctor appointment and was told she had 6 months or less to live due to lung cancer and was referred for hospice services.</p> <p>*8/12/16 at 10:57 am, Resident #8 signed the hospice agreement and told her daughter about her diagnosis.</p> <p>*8/17/16 at 3:25 pm, ..." [resident] refused to go to her MH appointment today. [Resident] informed the SSD she needs more time to get ready, doesn't feel like going. MH does not help here, she is dying anyway."</p> <p>On 8/30/16 at 4:32 pm, Resident #8 discontinued her hospices services and told the social worker she did not feel she needed the hospice service.</p> <p>On 9/9/16 at 10:35 am, Resident #8 was informed by the SW that she canceled her mental health appointment 3 times and the clinic had discontinued their services for her. Resident #8 stated that she was depressed and dying and it was not helping her.</p> <p>On 9/22/16 at 4:03 pm, it was documented Resident #8 had a care plan change with the following interventions: Observe for signs and symptoms or racing thoughts or euphoria, increased irritability, frequent mood changes, pressured speech, flight of ideas, marked changed in need for sleep, agitation, or hyperactivity, weight loss, weight gain, loss of interest, thoughts of death.</p> <p>Resident #8's behavior monitor flow sheet, with a look back period of 30 days, was blank with the following behaviors being monitored: hitting,</p>	{F 329}			

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{F 329}	<p>Continued From page 19</p> <p>kicking, pushing, scratching grabbing and abusing others sexually, biting, no physical behaviors, resident not available, resident refused, and not applicable. The flow sheet did not contain the behaviors that needed to be monitored according to the recent care plan update.</p> <p>On 10/26/16, the DON reviewed the blank behavior monitoring flow sheet. The DON said the CNAs used the flow sheet, and if the CNAs noted any of the behaviors they would report them to the LNs. When asked about the behaviors mentioned on the care plan to be observed, the DON said the LNs only charted by exception. The DON said if there was a behavior then LNs would document it, no documentation meant the resident did not show any the behaviors.</p> <p>3. Resident #14 was admitted to the facility on 8/19/16 with multiple diagnoses including dementia with behaviors, major depression, and a personal history of other mental and behavioral disorders.</p> <p>Resident #14's 8/26/16 Admission MDS Assessment, documented no behaviors, hallucinations, or delusions.</p> <p>Resident #14's care plan, dated 8/22/16, included the use of antipsychotic medications related to history of mental and behavior disorders. The interventions included:</p> <p>*Monitor for a significant decline in function and/or substantial difficulty receiving needed care (e.g. not eating resulting in weight loss, fear, and</p>	{F 329}			

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OMB NO. 0938-0391

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{F 329}	<p>Continued From page 20 not bathing leading to skin breakdown or infection).</p> <p>*Monitor for behavioral symptoms that present a danger to the resident or others.</p> <p>*Monitor for symptoms of mania or psychosis (such as auditory, visual, or other hallucinations; delusions).</p> <p>*Goal - The resident will be free of any discomfort or adverse side effects from antipsychotic medication use through the target date of 11/20/16.</p> <p>Resident #14's Physician's Medication Review Report, dated October 2016, documented Resident #14 received Aricept 23 mg daily and Namenda 10 mg daily, both for Alzheimer's Disease, and Zyprexa 2.5 mg daily at bedtime for personal history of other mental and behavioral disorders.</p> <p>Resident #14's behavior monitor flow sheets, dated October 2016, included monitoring of aggressive behaviors, mood, depression, or physical abusive behaviors. No behaviors were documented. On 10/18/16, an incident and accident report documented Resident #14 slapped another resident across the face. There were no behaviors documented on the behavior monitor flow sheets for the incident.</p> <p>On 10/26/16 at 2:00 pm, the DON stated Resident #14 was admitted to the facility with both medications for Alzheimer's disease. The DON said she did not know the reason Resident #14 required both medications. The DON</p>	{F 329}		

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{F 329}	<p>Continued From page 21</p> <p>documented in the nurses' notes, on 10/18/16, that she discussed Resident #14's medications and behaviors with the pharmacist and the pharmacist was to complete a review. The DON was unable to find documentation of the review of medications by the pharmacist. The DON also stated staff should have documented Resident #14's 10/18/16 incident of aggressive behavior on the behavior monitor flow sheets.</p> <p>4. Resident #10 was admitted to the facility on 6/30/15, with multiple diagnoses including dementia with behaviors, delusional disorder, depression, and violent behaviors.</p> <p>Resident #10's Quarterly MDS Assessment, dated 8/24/16, documented no depression, hallucinations, or delusions present. It also stated Resident #10 had demonstrated physical and verbal abuse three times in the last 7 days.</p> <p>Resident #10's Physician Medication Review Report, dated October 2016, documented Resident #10 received Trazodone 50 mg daily for insomnia.</p> <p>The October 2016 MAR documented Resident #10 received Trazodone 50 mg daily for insomnia. There was no daily documentation of the number of hours Resident #10 slept.</p> <p>Resident #10's care plan, dated 2/1/16 and revised on 9/26/16, documented Resident #10 was on an antidepressant related to insomnia. The interventions included:</p> <p>*Monitor for increased risk for falls.</p>	{F 329}			

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{F 329}	<p>Continued From page 22</p> <p>*Consult with pharmacy, health care provider, etc. to consider dosage reduction when clinically appropriate.</p> <p>On 10/26/16 at 2:00 pm, the DON stated Resident #10's hours of sleep were not monitored. The DON stated the nurses documented the effectiveness of the medication in the nurses' notes. The DON was unable to provide documentation related to the effectiveness of Trazodone.</p> <p>5. Resident #1 was admitted to the facility on 12/11/15, with multiple diagnoses including depression.</p> <p>Resident #1's quarterly MDS assessment, dated 8/20/16, documented she exhibited no behaviors or hallucinations, little interest in doing things, and delusions.</p> <p>Physician orders for Resident #1, dated 7/31/16, included Effexor XR 225 mg in the morning, for Major Depressive Disorder.</p> <p>Resident #1's cognitive care plan, dated 8/25/16, documented staff were to consult with the pharmacy and physician to consider a dosage reduction when it was determined to be clinically appropriate.</p> <p>Resident #1's behavior monitor flow sheets, printed 10/26/16, did not include documentation over the past 30 days related to the use of Effexor and its effectiveness in treating Resident #1's depressive symptoms.</p> <p>Resident #1's Social Service Progress notes,</p>	{F 329}			

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{F 329}	<p>Continued From page 23 dated 7/25/16-10/26/16, documented there were no behaviors.</p> <p>Nurses' notes documented the following:</p> <p>* 8/16/16: Resident #1 was "in the day room eating a snack and watching TV...alert, oriented and in a good mood..."</p> <p>*10/10/16: "... She has no complaints, no new interventions."</p> <p>*10/26/16: "...up and out of her room today...in the day room, reading the paper and visiting with residents."</p> <p>On 10/25/16 at 3:45 pm, the DON stated she expected to see the nurses monitoring for symptoms and behaviors related to depression on the behavior monitoring flow sheets, to allow them to determine if a GDR of the Effexor was warranted.</p>	{F 329}		