



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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3232 Elder Street
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March 24, 2017

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

Provider #: 135085

Dear Mr. Davidson:

On **March 9, 2017**, 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. 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.

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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 **April 3, 2017**. Failure to submit an acceptable PoC by **April 3, 2017**, may result in the imposition of penalties by **April 28, 2017**.

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 **April 13, 2017 (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 **June 7, 2017**. A change in the seriousness of the deficiencies on **April 23, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **June 7, 2017** includes the following:

Denial of payment for new admissions effective **June 7, 2017**. [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 **September 5, 2017**, 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 **June 7, 2017** 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>

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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 **April 3, 2017**. If your request for informal dispute resolution is received after **April 3, 2017**, 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,

A handwritten signature in black ink that reads "Nina Sanderson for". The signature is written in a cursive style.

Nina Sanderson, LSW, Supervisor
Long Term Care

NS/lj
Enclosures

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

PRINTED: 04/14/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/09/2017
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - BOISE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 survey conducted at the facility from March 6, 2017 to March 9, 2017. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Edith Cecil, RN Marcia Mital, RN Rachel Moorhead Lopez, MSW Survey Abbreviations: ADL = Activities of Daily Living CNA = Certified Nursing Assistant CVA = Cerebrovascular Accident (stroke) DON = Director of Nursing hemi = half LN = Licensed Nurse MDS = Minimum Data Set MLS = Milliliters RN = Registered Nurse R/T = Related To UM = Unit Manager W/C = Wheelchair	F 000			
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff	F 241	General Disclaimer	4/13/17	

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

TITLE

(X6) DATE

Electronically Signed

04/03/2017

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 241	<p>Continued From page 1</p> <p>interview, it was determined the facility failed ensure catheter bag privacy covers were used to promote the dignity of residents. This was true for for 1 of 4 sampled residents (Resident #4) who had catheters. This created the potential for Resident #4 to experience embarrassment or loss of self-esteem if her catheter bag, potentially with urine in it, was viewed by visitors, other residents, and others in the facility. Findings include:</p> <p>Resident 4 was admitted to the facility with diagnoses which included spina bifida [a birth defect in which the spinal column does not close all of the way] and urostomy [surgical procedure to create an opening in the abdomen for the drainage urine when the bladder is not functioning properly or is removed].</p> <p>On 3/6/17 at 11:03 am, 12:00 pm, 2:15 pm, and 3:28 pm, Resident #4 was observed lying in bed without a privacy cover on her catheter bag.</p> <p>Additionally, on 3/7/17 at 8:06 am, Resident #4 was observed lying in bed with her catheter bag uncovered.</p> <p>On 3/7/17 at 8:15 am, Unit Manager #1 said the catheter bag should have been covered.</p>	F 241	<p>Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations manual.</p> <p>F241 - Dignity & Respect</p> <p>Resident Specific</p> <p>The care manager covered resident #4's catheter bag immediately upon discovery and the catheter bag is now kept covered.</p> <p>Other Residents</p> <p>All residents with catheter bags have the potential to be affected by this practice. The care managers completed an audit of all residents with catheter bags on 3/10/17 and 3/21/17 to ensure they are covered.</p> <p>Facility System</p> <p>In-servicing regarding resident dignity and</p>		

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F 241	Continued From page 2	F 241	ensuring catheter bags are covered has been provided for nursing on 3/30/17, 4/3/17, and any one-on-ones by 4/13/17. Monitor Starting on 4/7/17, the care managers will audit weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure resident catheter bags are covered. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification. Date of Compliance April 13, 2017		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care.	F 280		4/13/17	

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F 280	Continued From page 3 (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 280			

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F 280	<p>Continued From page 4</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. 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 the care plan for 1 of 15 (Resident #8) sampled residents whose care plans were reviewed, was updated to include the need for use of a hemi-tray [half of tray on the right side only] on his wheelchair to assist with arm positioning. This created the potential for Resident #8 to experience increased discomfort or pain, or decreased range of motion, in his right arm and/or shoulder, if staff failed to use the hemi-tray due lack of direction in his care plan. Findings include:</p> <p>Resident #8 was admitted to the facility 4/11/02, with diagnosis of CVA [cardiovascular accident, commonly known as a stroke] with right side hemiplegia [half of the body is paralyzed] and</p>	F 280	<p>F280 - Care Planning</p> <p>Resident Specific</p> <p>The care plan for resident #8 was updated on 3/10/17 to address the hemi-tray.</p> <p>Other Residents</p> <p>All residents with hemi-trays could be affected. The care managers completed an audit on 3/10/17 and 3/21/17 of all residents with hemi-trays to ensure they are care planned.</p> <p>Facility System</p>		

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F 280	<p>Continued From page 5</p> <p>hemiparesis [half of the body is weakened or has suffered partial loss of movement. Hemiparesis is a less severe form of hemiplegia], aphasia [loss of ability to understand or express speech], and right side spasticity [condition in which certain muscles are continuously contracted].</p> <p>A Physician's Order Summary Report, dated 9/19/13, documented an order for a right hemi-tray to be placed on Resident #8's wheelchair for positive positioning [to positively impact body shape and function, increase comfort, and decrease pain].</p> <p>Resident #8's quarterly MDS assessment, dated 12/8/16, documented functional limitations in his upper extremity [shoulder/arm] range of motion [full movement potential of a joint] on one side.</p> <p>A Physical Device and Restraint Review assessment, dated 1/16/17, documented the use of a right hemi-tray on his wheelchair to assist with arm positioning.</p> <p>Resident #8's current Care Plan, initiated on 12/24/13 and revised on 7/8/16, did not document the use of the hemi-tray to assist with arm positioning.</p> <p>On 3/7/17 at 11:00 am, Resident #8 was in his wheelchair. There was a hemi-tray positioned on the right arm rest of his wheelchair and his right arm was resting on his lap.</p> <p>On 3/7/17 at 11:50 am, Resident #8 was observed in the dining room sitting in his wheelchair. There was a hemi-tray positioned on the right arm rest of the wheelchair and his right</p>	F 280	<p>The nurses have been in-serviced regarding resident equipment and ensuring hemi-trays are care planned on 3/30/17, 4/3/17, and for any one-on-ones by 4/13/17.</p> <p>Monitor</p> <p>Starting on 4/7/17, the care managers will audit residents with hemi-trays weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure the care plan has been updated. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification.</p> <p>Date of Compliance</p> <p>April 13, 2017</p>		

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F 280	Continued From page 6 arm was resting on his lap. On 3/7/17 at 1:00 pm, Resident #8 was sitting in his wheelchair in the dining room after his mid-day meal. There was a hemi-tray positioned on the right arm rest of his wheelchair and his right arm was resting on his lap. Resident #8 was asked if he used the hemi-tray for his arm, and shook his head "no." On 3/8/17 at 11:30 am, Resident #8 was sitting in his wheelchair in the dining room. There was a hemi-tray positioned on the right arm rest of the wheelchair and his right arm was resting on his lap. On 3/8/17 at 1:30 pm, Resident #8 was sitting in his wheelchair in the dining room. There was a hemi-tray positioned on the right arm rest of the wheelchair and his right arm was resting on his lap. On 3/9/17 at 9:00 am, RN #4 stated Resident #8 had the hemi-tray on his wheelchair for as long as she could remember, "at least 4 or 5 years." On 3/9/17 at 9:30 am, Unit Manager #2 reviewed Resident #8's Care Plan. She stated the hemi-tray was not on the care plan and would be added to it.	F 280			
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State	F 431		4/13/17	

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F 431	<p>Continued From page 7 law permits, but only under the general supervision of a licensed nurse.</p> <p>(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--</p> <p>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>(g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>(h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of</p>	F 431		

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F 431	<p>Continued From page 8</p> <p>controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure a vial of Lantus insulin was dated when opened, and expired inhaler solution and medications were removed from medication carts and not available for administration to residents. This was true for 2 of 5 medication carts checked for expired medications (Eagle Unit cart and Syringa II Unit cart). This failed practice created the potential for residents to receive expired medications with decreased efficacy. Findings include:</p> <p>a. On 3/8/17 at 3:00 pm, during inspection of the Medication Cart on the Eagle Unit with RN #3 present, the following were found:</p> <ul style="list-style-type: none"> * One Lantus insulin vial lacked the date of when it was opened. RN #3 stated she did not know when the vial was opened and said the vial should have been dated when it was first opened. The manufacturer's packet insert for Lantus insulin states, "Vials must be discarded 28 days after being opened." * A multi-use bottle of folic acid [helps the body make new cells, including new red blood cells] with a manufacturer expiration date of 2/2017. * A multi-use bottle of cranberry supplement 	F 431	<p>F431 - Medication Storage/Labeling</p> <p>Resident Specific</p> <p>Upon discovery, any expired medications and/or insulin not labeled were properly discarded by the care managers.</p> <p>Other Residents</p> <p>Expired medications have the potential to affect all residents who receive medications. The care managers inspected each medication cart on 3/10/17 and 3/21/17 to ensure expired medications were discarded and any open vials of insulin were dated.</p> <p>Facility System</p> <p>In-servicing has been completed for licensed nurses to ensure any expired medications are properly discarded and any open vials of insulin are dated on 3/30/17, 4/3/17, and for any one-on-ones by 4/13/17.</p> <p>Monitor</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	Continued From page 9 [helps prevent urinary tract infections] with a manufacturer expiration date of 1/2017. * Ipratropium bromide/Albuterol [an inhaled medication used to treat breathing problems] 0.5 mg/3 mg per 3 mls single use vials with a manufacturer expiration date of 2/2017. The manufacturer's packet insert for this medication states, "Do not use after the expiration (EXP) date..." b. On 3/8/17 at 3:30 pm, during inspection of the Medication Cart on Syringa II Unit with RN #2 present, the following were found: * Baclofen [muscle relaxer used to treat spasms], 10 mg tablets: - 30 tablets with expiration date 2/1/17. - 30 tablets with expiration date 2/21/17. - 26 tablets with expiration date 2/21/17. The manufacturer's packet insert for Baclofen states, "Do not take the tablets after the expiration date..." * Dok Plus [stool softener] with 29 tablets with an expiration date of 8/12/15.	F 431	Starting on 4/7/17, the care managers will audit the medication carts weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure expired medications are being properly discarded and any open vials of insulin are dated. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification. Date of Compliance April 13, 2017		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and	F 441		4/13/17	

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F 441	<p>Continued From page 10</p> <p>communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);</p> <p>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct</p>	F 441		

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F 441	<p>Continued From page 11</p> <p>contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure residents' urinary catheter bags and catheter tubing were off of the floor. This was true for 1 of 4 sampled residents (Resident #4) reviewed who had urinary catheters. This deficient practice placed Resident #4 at risk of infection if the catheter bag and/or tubing were contaminated with infectious substances which may found on the floor. Findings include:</p> <p>Resident 4's was admitted to the facility with diagnoses which included spina bifida [a birth defect in which the spinal column not close all of the way] and urostomy [surgical procedure to create an opening in the abdomen for the drainage urine when the bladder is not functioning properly or is removed].</p>	F 441	<p>F441 - Infection Control</p> <p>Resident Specific</p> <p>The catheter bag for Resident #4 was stored off of the floor upon notification and continues to be stored off the floor.</p> <p>Other Residents</p> <p>All residents with catheters have the risk of being infected when their catheter bags are touching the floor. The care managers completed an audit on 3/10/17 and 3/21/17 of all residents with catheter bags to ensure the catheter bags are not touching the floor.</p> <p>Facility System</p>		

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F 441	Continued From page 12 Resident #4 was observed lying in bed with her catheter bag and tubing laying on the floor next to her bed on 3/6/17 at 11:03 am and 12:00 pm. On 3/7/17 at 8:15 am, Unit Manager #1 stated the catheter bag and tubing should not have been on the floor. The facility's policy, titled Catheterization, dated 9/2012, documented, "Catheters will always be properly secured...Catheter tubing never should be allowed to touch the floor."	F 441	In-servicing was completed for nursing on 3/30/17, 4/3/17, and any one-on-ones by 4/13/17 regarding infection control and making sure resident catheter bags are not touching the floor. Monitor Starting on 4/7/17, the care managers will audit weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure resident catheter bags are not touching the floor. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification. Date of Compliance April 13, 2017		
F 526 SS=D	483.70(o)(1)-(4) Hospice (o) Hospice services. (1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident	F 526		4/13/17	

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F 526	<p>Continued From page 13 requests a transfer.</p> <p>(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:</p> <p>(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.</p> <p>(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:</p> <p>(A) The services the hospice will provide.</p> <p>(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.</p> <p>(C) The services the LTC facility will continue to provide based on each resident's plan of care.</p> <p>(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.</p> <p>(E) A provision that the LTC facility immediately notifies the hospice about the following:</p>	F 526			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 526	Continued From page 14 (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.	F 526			

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F 526	Continued From page 15 (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. (3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is	F 526			

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F 526	<p>Continued From page 16 responsible for the following:</p> <p>(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.</p> <p>(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.</p> <p>(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.</p> <p>(iv) Obtaining the following information from the hospice:</p> <p>(A) The most recent hospice plan of care specific to each patient.</p> <p>(B) Hospice election form.</p> <p>(C) Physician certification and recertification of the terminal illness specific to each patient.</p> <p>(D) Names and contact information for hospice personnel involved in hospice care of each patient.</p> <p>(E) Instructions on how to access the hospice's 24-hour on-call system.</p>	F 526			

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F 526	<p>Continued From page 17</p> <p>(F) Hospice medication information specific to each patient.</p> <p>(G) Hospice physician and attending physician (if any) orders specific to each patient.</p> <p>(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.</p> <p>(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.20. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure coordination of care, including a delineation of duties between the hospice provider and the facility for 2 of 3 residents (#12 & #13) reviewed for hospice care. This created the potential for Resident #12 and Resident #13 to receive inadequate care from the facility and/or hospice agency if the care and services to be provided by each, were not clearly described and documented in their respective records. Findings include: The facility's Hospice Services Policy and Procedure, revised September 2016, documented:</p>	F 526	<p>F526 - Hospice Resident Specific</p> <p>A meeting was held with the hospice provider to go over the delineation of duties between hospice and the facility. Delineation of hospice and facility duties as well as updating the care plan was completed for Resident's #12 and #13 on 3/31/17.</p> <p>Other Residents</p> <p>All residents on hospice have the potential to be affected. The care</p>		

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F 526	<p>Continued From page 18</p> <p>* "The hospice provider's plan of care is integrated with the location's [facility's] comprehensive care plan..."</p> <p>* "A coordinated comprehensive plan of care shall be jointly developed by the rehab/skilled care location [facility] and hospice."</p> <p>* "The plan of care must include directives for managing pain and other symptoms associated with hospice care, and must be revised and updated as necessary to reflect the resident's current clinical, psychosocial and spiritual condition."</p> <p>The above policy was not followed. Examples include:</p> <p>1. A Significant Change MDS, dated 12/1/16, documented Resident #12 was receiving Hospice Services while a resident at the facility.</p> <p>The hospice agency's care plan for Resident #12, dated 11/29/16, documented Resident #12 would be receiving Hospice Services, and included a terminal diagnosis of lymphoma [a cancer that starts in cells that are part of the body's immune system]. Resident #12's hospice agency care plan did not include delineation of duties between hospice staff and facility staff, to ensure her needs were met and her care was coordinated between the two entities.</p> <p>On 3/8/17 at 11:30 am, Resident #12 was observed sitting in an electric wheelchair waiting for staff to assist her to the dining room for lunch.</p> <p>The section of Resident #12's facility care plan related to nutrition, last revised on 12/8/16,</p>	F 526	<p>managers completed an audit on 3/10/17 and 3/21/17 of all residents on hospice to ensure there is a clear delineation of hospice duties and that the care plan has been updated.</p> <p>Facility System</p> <p>In-servicing has been completed for nursing and social services on 3/30/17, 4/3/17, and any one-on-ones by 4/13/17 regarding the delineation of duties for hospice and the facility and updating the care plan.</p> <p>Monitor</p> <p>Starting on 4/7/17, the care managers will audit weekly x 4, bi-weekly x 4, and then monthly x 3 residents on hospice to ensure a clear delineation of duties and that the care plan has been updated. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification.</p> <p>Date of Compliance</p> <p>April 13, 2017</p>		

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F 526	<p>Continued From page 19</p> <p>documented Resident #12, "Has a potential nutritional problem r/t [related to] DM [Diabetes Mellitus], heart disease, obesity, lymphoma with hospice care." The related interventions documented Resident #12 was to be provided with nutritional supplements as ordered, and her intake at each meal was to be monitored and recorded. The delineation of duties between facility staff and hospice staff was not documented.</p> <p>Another section of Resident #12's facility care plan, revised on 12/16/16, documented Resident #12, "Has [name of Hospice] care due to terminal diagnosis." The related interventions documented, "Attempt non-pharmacological interventions: elevate legs, warm blanket, repositioning." The duties of facility staff and hospice staff were not documented to ensure duties were clearly delineated.</p> <p>A Quarterly MDS, dated 2/14/17, documented Resident #12 was still receiving Hospice Services while a resident at the facility.</p> <p>During an interview with CNA #1 on 3/8/17 at 9:55 am, Certified Nursing Assistant #1 stated facility staff provided all of Resident #12's care.</p> <p>During an interview with the Director of Nursing [DON] on 3/8/17 at 2:00 pm, the DON stated, facility staff provided all care. The DON said all facility staff knew they were responsible for all resident care. The DON stated facility staff were to verbally communicate that to hospice staff, but could not ensure that communication always took place.</p>	F 526			

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F 526	<p>Continued From page 20</p> <p>During an interview with LN #2 on 3/8/17 at 2:45 pm, she stated facility staff provided all primary care, including baths and showers. LN #2 stated she did not know if the delineation of duties between facility and hospice staff was written down, but that everyone knew the delineation. LN #2 stated that after review of Resident #12's facility and hospice agency care plans, she could see the plans did not specify the duties of facility and hospice staff.</p> <p>During an interview with Unit Manager #2 [UM #2], on 3/8/17 at 3:40 pm, Resident #12's medical record was reviewed. UM #2 stated the specific delineation of duties between hospice and the facility staff for Resident #12, was not documented in her record.</p> <p>CNA #2 was interviewed on 3/9/17 at 8:00 am. CNA #2 stated staff talked one-on-one about what hospice staff could and could not do. CNA #2 stated the care plan would be the first place to check to find delineation of duties.</p> <p>During an interview with LN #1 on 3/9/17 at 8:25 am, LN #1 stated she thought the facility care plan described the duties of facility and hospice staff, but said she then reviewed Resident #12's facility care plan and did not find anything specific.</p> <p>During a second interview with the DON on 3/9/17 at 8:45 am, the DON stated that according to Resident #12's facility care plan, facility staff should be offering nutritional supplements, but that the care plan was not very clear or specific. The DON stated, if Resident #12 were complaining of pain in the presence of hospice</p>	F 526			

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F 526	<p>Continued From page 21</p> <p>staff, the hospice staff were to tell facility staff Resident #12 is in pain and the facility nurse would administer pain medications. The DON said the communication between facility and hospice staff was verbal, and after reviewing Resident #12's facility care plan, understood the delineation of duties was not clear.</p> <p>2. Resident #13 was admitted to the facility on 3/28/11, with multiple diagnoses including heart failure.</p> <p>Resident #13's March 2017 Order Summary Report, documented a 10/22/13 physician order for hospice services from a local hospice provider.</p> <p>Resident #13's current facility care plan included a focus area, dated 3/11/15, which documented, "[Resident #13] has hospice R/T a terminal prognosis," with one intervention, "Encourage support system of family and friends."</p> <p>Resident #13's current hospice provider care plan, dated 2/23/17, documented interventions for spiritual, ADL, and social work needs.</p> <p>Resident #13's record did not contain a delineation of duties between the hospice agency and the facility.</p> <p>On 3/8/17 at 11:25 am, Unit Manager #2 said Resident #13's record did not include a delineation of duties, but that the facility completed all cares and administered all medications. She said more senior staff were to verbally educate new staff as to what services the hospice provided versus those the facility</p>	F 526			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/09/2017
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - BOISE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 526	Continued From page 22 provided. On 3/8/17 at 2:00 pm, the DON said Resident #13's facility care plan related to hospice services should be more detailed and include the name of the hospice agency providing services to Resident #13. She said all cares were provided by the facility and she counted on facility staff to verbally pass that information to the hospice agency staff who cared for Resident #13. The DON said medications associated with Resident #13's terminal diagnosis were paid for by the hospice agency and provided to the facility through the same pharmacy the facility used. The DON said facility staff administered all of Resident #13's medications, including those provided by the hospice agency. She said Resident #13's record did not specify the medications provided by the hospice agency versus the medications provided by the facility.	F 526			