



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

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

February 18, 2018

Remick "Micky" Clark, Administrator
Good Samaritan Society - Idaho Falls Village
840 East Elva Street
Idaho Falls, ID 83401-2899

Provider #: 135092

Dear Mr. Clark:

On **February 7, 2018**, 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 **December 29, 2017**. 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(g)(14) -- Notify Of Changes (injury/decline/room, Etc)
F0280 -- S/S: D -- 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) -- Right To Participate Planning Care-Revise Cp
F0281 -- S/S: D -- 483.21(b)(3)(i) -- Services Provided Meet Professional Standards

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 **February 28, 2018**.

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*.

As noted in the Bureau of Facility Standards' letter of **November 22, 2017**, following the survey of **October 27, 2017**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for

- Civil Monetary Penalty
- Denial of Payment for New Admissions effective **January 27, 2018**
- Termination on **April 27, 2018**

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

If you believe the deficiencies have been corrected, you may contact please contact Debby

Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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)

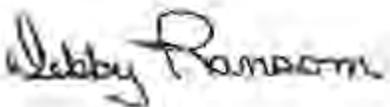
[2001-10 Long Term Care Informal Dispute Resolution Process](#)

[2001-10 IDR Request Form](#)

This request must be received by **February 28, 2018**. If your request for informal dispute resolution is received after **February 28, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards

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

PRINTED: 03/26/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135092	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/07/2018
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 840 EAST ELVA STREET IDAHO FALLS, ID 83401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS The following deficiencies were cited a revisit survey conducted at the facility from February 6, 2018 through February 7, 2018. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Cecilia Stockdill, RN Survey Abbreviations: A-fib = atrial fibrillation (irregular heart rhythm) BG = blood glucose CDM = Certified Dietary Manager CHF = congestive heart failure CNA = Certified Nurse Assistant DON = Director of Nursing GERD = Gastroesophageal Reflux Disease (stomach acid problem) HS = bedtime LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set MG = Milligram ML = milliliter mmHg = millimeters of mercury MRSA = Methicillin Resistant Staphylococcus Aureus MS = Multiple Sclerosis PEG = Percutaneous Endoscopic Gastrostomy (a feeding tube) RN = Registered Nurse	{F 000}			
{F 157} SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes.	{F 157}		3/9/18	

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

TITLE

(X6) DATE

Electronically Signed

02/24/2018

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>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or</p>	{F 157}			

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{F 157}	<p>Continued From page 2</p> <p>State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure the resident's physician was immediately notified of significant changes in the resident's clinical condition. This was true for 4 of 7 (#s 1, 2, 10, and 13) sample residents when the physician was not immediately notified of out of range pulse (heart rate), blood pressure, and BG (blood glucose) readings. This failure had the potential for harm should the resident require a change in care. Findings include:</p> <p>1. According to the American Heart Association (updated 1/29/18), a normal pulse is between 60-100 beats per minute.</p> <p>Resident #13 was admitted on 1/9/18 with multiple diagnoses including hypertension (high blood pressure), malignant neoplasm (cancer), acute respiratory failure, pulmonary edema (inflammation of the respiratory system), and emphysema.</p> <p>Resident #13's care plan documented the following:</p> <p>* The Resident had emphysema exhibited by shortness of breath and oxygen use. Interventions were initiated on 1/11/18 that directed staff to monitor for signs and symptoms</p>	{F 157}	<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>1. Resident #13 had abnormal pulse and B/P readings reported to the physician on 2/08/2018. For tachycardia doctor ordered Coreg however resident continues to have low blood pressure readings so Coreg was discontinued. After doctor reviewed resident's medications, parameters for notifications were revised to meet the specific needs of this resident.</p> <p>Resident #2-Had abnormal B/P readings reported to the physician on 1/26/18 for reading from 1/22/18 to 1/26/18. Doctor</p>		

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{F 157}	<p>Continued From page 3 of respiratory distress, blood oxygen saturation and increased heart rate and report to the health care provider.</p> <p>Resident #13's Weights and Vitals Summary, dated 1/9-2/7/18, documented the following:</p> <p>* The resident's blood pressure was 96/67 on 1/19/18 at 1:16 PM, and 90/65 on 1/22/18 at 7:15 AM.</p> <p>* From 1/10-2/7/18, Resident #13's pulse was over 100 beats per minute when monitored 11 out of 15 times.</p> <p>There was no documentation the physician was notified when Resident #13's blood pressure and pulse were out of expected parameters.</p> <p>On 2/6/18 at 2:35 PM, Resident #13 said he was not aware of any times his blood pressure was low or heart rate was high since being in the facility.</p> <p>On 2/7/18 at 10:00 AM, the DON said the facility used blood pressure parameters according to the American Heart Association, and she would expect the nurse to notify the physician if the resident's blood pressure was less than 100/60 or greater than 140/90.</p> <p>On 2/7/18 at 11:25 AM, the DON said Resident #13's increased heart rate could be associated with medication, and the physician should have been notified of the resident's tachycardia and blood pressure readings that were out of the expected parameters. The DON said she could not find documentation the physician was</p>	{F 157}	<p>was notified on 2/04/18 that Diltiazem was held for systolic blood pressure less than 60, on 2/16/2018 notification for week of 2/09/18 to 2/16/18 that resident had blood pressure out of set parameters with systolic blood pressures greater than 140 and diastolic blood pressure readings less than 60. Currently has hold parameters.</p> <p>Resident #2 -Had oxygen levels less than 90% during the day was reported to the provider on 2/09/2018. Orders obtained to have resident wear oxygen during the day as well as to continue to wear during the night to keep sat >90%.</p> <p>Resident #10- Had abnormal BG levels reported to the primary care provider on 2/12/18 of blood sugar readings from 2/06/18 to 2/12/18. Resident saw provider on 2/13/18 and blood sugars were reviewed. Resident agreed with provider that she would limit her intake of diet pop and diet cocoa to see if this would improve her readings, no other changes were ordered at that time. Provider again notified on 2/16/18 of elevated blood sugar readings. To reduce confusion about this resident's notifications, all abnormal blood sugars and blood pressures reading will be reported to Aspen hospice who will report to MD or FNP.</p> <p>Resident #1 -Had abnormal pulse and blood pressure values reported to physician on 2/08/2018. Pulses and blood pressure monitoring was added to be checked daily. Notification parameters were obtained and added to resident's</p>		

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{F 157}	<p>Continued From page 4 notified.</p> <p>2. Resident #2 was admitted on 6/10/11 and re-admitted on 5/25/12 with multiple diagnoses essential hypertension (high blood pressure).</p> <p>a. Resident #2's hypertension care plan, initiated 4/25/17, directed staff to monitor, document, report to health care provider as needed for any signs/symptoms of malignant hypertension (e.g., headache, visual problems, confusion, disorientation, lethargy, nausea and vomiting, irritability, seizure activity, difficulty breathing).</p> <p>Resident #2's February 2018 Medication Review Report, documented the following:</p> <p>* Diltiazem (blood pressure medication) tablet 30 mg via PEG tube was ordered on 12/5/17</p> <p>* Hold the medication if blood pressure less than 100 systolic (top number) or less than 60 diastolic (bottom number).</p> <p>Resident #2's January 2018 MAR documented the diastolic blood pressure was less than 60 in 18 out of 93 opportunities.</p> <p>Resident #2's February 2018 MAR documented the diastolic blood pressure was less than 60 in 3 out of 17 opportunities and systolic blood pressure was less than 100 in 1 out of 17 opportunities.</p> <p>A facility fax to the physician, dated 1/16/18, documented Resident #2's physician was notified of her blood pressure readings from 1/9-1/16/18 via this fax. The physician responded, "noted" on</p>	{F 157}	<p>EMAR for monitoring.</p> <p>2. All residents with medication or conditions that involve the need for pulse, B/P, oxygen level, or blood glucose level, parameters will be included in the physician's orders or will be added to daily nursing tasks if no medications are given for that condition. The order will also include the provider's requirements for notification to be specific to resident's needs such as each episode, daily, weekly, etc. Daily monitoring of vital signs will include rechecking blood pressure readings for effectiveness of medications.</p> <p>3. The DNS or designee will provide education to the nursing staff by 3/08/2018 regarding the need for complete physician orders including parameters, how often the provider needs to be notified, and the interventions needed when parameters are not met. This education will include the need to re-check the vital sign after medication is given, within 1-2 hours after administration.</p> <p>4. The DNS or designee will audit all physician orders with medications that may require vital sign, O2 or blood glucose parameters. This audit will also include medication pass observations to assure nurses are checking vital signs, oxygen levels, or BG levels. This audit will also include the notification to provider according to the provider preference.</p>		

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{F 157}	<p>Continued From page 5 1/17/18.</p> <p>A facility fax to the physician, dated 1/26/18, documented Resident #2's physician was notified of her blood pressure readings from 1/19-1/26/18 via this fax. The physician responded, "observe" on 1/29/18.</p> <p>On 2/7/18 at 10:00 AM, the DON said the facility uses blood pressure parameters according to the American Heart Association, and she would expect the nurse to notify the physician if the resident's blood pressure was less than 100/60 or greater than 140/90.</p> <p>b. According to the National Institutes of Health (7/16/15), a pulse oximetry reading (a device that measures the percentage of oxygen saturation in the blood) of less than 90 indicates hypoxemia (a low oxygen level).</p> <p>Resident #2's altered respiratory status care plan documented oxygen therapy at 2 liters by nasal cannula (tubing) with humidity at bedtime was initiated on 11/9/17. The care plan interventions, initiated 4/25/17, directed staff to monitor for signs and symptoms of respiratory distress and report to health care provider as needed regarding "increased respirations, decreased pulse oximetry, increased heart rate (tachycardia)..."</p> <p>Resident #2's February 2018 Medication Review Report documented oxygen at 2 liters per minute via nasal cannula at "bedtime for Desaturation" (decreased oxygen level in the blood) was ordered on 11/4/17. There were no parameters ordered regarding when to monitor the resident's</p>	{F 157}	<p>These audits will be done weekly X4 and then monthly X3 with the DNS or designee reporting the findings to the QAPI committee monthly. The QAPI committee will determine if further auditing is needed.</p>		

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{F 157}	<p>Continued From page 6</p> <p>oxygen level and when to notify the physician of abnormal oxygen saturation levels.</p> <p>Resident #2's Weights and Vitals Summary, dated 12/29/17-2/7/18, documented her oxygen saturation was checked, on average, once a day between 6:30 and 10:30 AM with occasional gaps of one to three days between checking the oxygen saturation. Resident #2's oxygen saturation was less than 90% on room air during waking hours on 4 of 26 documented occasions.</p> <p>There was no documentation Resident #2's physician was notified regarding the oxygen saturation readings that were out of the expected parameters.</p> <p>On 2/7/18 at 10:20 AM, the DON said she would expect staff to check Resident #2's oxygen saturation daily when the oxygen was on at night to see if her oxygen level decreased, that staff could put oxygen back on the resident if the oxygen saturation was less than 90% and should notify the physician. The DON said Resident #2's orders were not complete and the orders should include checking the oxygen saturation and to place oxygen on the resident as needed if her oxygen saturation was less than 90%.</p> <p>3. Resident #10 was admitted on 10/5/17 with multiple diagnoses including Type 2 diabetes mellitus.</p> <p>Resident #10's diabetes care plan, initiated 1/12/18, directed staff to monitor/report hyperglycemia (high blood glucose levels) or hypoglycemia (low blood glucose levels).</p>	{F 157}			

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{F 157}	<p>Continued From page 7</p> <p>Resident #10's February 2018 Medication Review Report documented Humalog (insulin) to be administered per sliding scale (based on the results of the blood glucose level) and to notify the physician for blood glucose levels less than 70 or greater than 300.</p> <p>Resident #10's Weights and Vital Summary, dated 2/6/18 at 4:32 PM, documented her BG readings were over 300 on 46 occasions between 12/26/17-2/6/18.</p> <p>A Communication/Visit with Physician Progress Note, dated 1/7/18 at 6:52 PM, documented the physician was notified of a BG reading of 396.</p> <p>A Progress Note, dated 2/3/18 at 11:39 PM, documented the nurse called hospice to update them regarding a BG of 507 at 9:00 PM, and the BG was 354 at 11:15 PM. The nurse was waiting for a return call from hospice.</p> <p>Resident #10's February 2018 MAR documented her BG was 437 on 2/6/18 and Humalog 10 units was given by injection at 12:00 plus 12 units of Humalog per sliding scale.</p> <p>Resident #10's eAdmin Record Progress Note, dated 2/6/18 at 10:52 AM, documented the resident was going out to lunch, the BG was taken before going out, and a peanut butter sandwich was sent "in case she starts feeling hypoglycemic."</p> <p>Resident #10's Communication/Visit with Physician Progress Note, dated 2/6/18 at 2:44 PM, documented the resident's BG was 437 before lunch, she was medicated with Humalog</p>	{F 157}			

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{F 157}	<p>Continued From page 8</p> <p>per the sliding scale, and the nurse was faxing "several days worth of blood sugars..." to the medical provider.</p> <p>On 2/6/18 at 2:50 PM, Resident #10 returned from being out for lunch. The resident said she did not feel any symptoms related to blood sugar levels.</p> <p>On 2/6/18, RN #1 said there had been some misunderstanding regarding who they were to notify regarding Resident #10's diabetes management. RN #1 said she called the resident's medical provider regarding the elevated BG and she "was not able to talk to her" so a note was faxed to the medical provider. RN #1 confirmed she gave the ordered insulin and sliding scale insulin to Resident #10 prior to her going out for lunch.</p> <p>On 2/6/18 at 3:38 PM, RN #1 said she was told to notify a certain provider regarding Resident #10's BG issues because she was on hospice. RN #1 said she put a note in the computer each time there was an elevated BG and "I think it's supposed to be done when it's over 300."</p> <p>On 2/7/17 at 11:51 AM, the DON said they could give insulin to Resident #10 up to a BG of 550 and should notify the physician or Nurse Practitioner of BGs greater than 300. The DON said there were a lot of people involved in Resident #10's care and she would look for documentation that the physician was notified of the elevated BGs.</p> <p>4. Resident #1 was admitted to the facility on 6/13/14 with multiple diagnoses including atrial fibrillation and hypertension.</p>	{F 157}			

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{F 157}	Continued From page 9 The facility's blood pressure medication policy, dated 2013, directed staff to check blood pressure and pulse for residents taking Amiodarone. Resident #1's January and February 2018 Medication Review Report documented an order, dated 4/21/15, for Amiodarone 200 mg by mouth one time a day for atrial fibrillation. There was no physician parameters for holding the medication or notifying the physician of when reading were outside the expected parameters. The Centers for Disease Control and Prevention and American Heart Association has classified high blood pressure as systolic (top number)was 140 mmHg or higher and diastolic (bottom number) was 90 or higher. A normal pulse rate was 60-100. Between 1/1/18 and 2/7/18, on 7 out of 38 days pulse rates ranged from 54 to 59 and 12 out of 38 days no pulses were documented on Resident #1; and on 20 out of 38 days the blood pressures documented on the January and February 2018 MAR ranged from 142/68 to 157/86. No documentation of physician notification could be found. On 2/7/18 at 9:50 AM, the DON said Resident #1's physician should have been notified of the low pulse rates and high blood pressure readings.	{F 157}			
{F 280} SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)	{F 280}		3/9/18	

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{F 280}	Continued From page 10 483.10 (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. (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.	{F 280}			

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{F 280}	Continued From page 11 483.21 (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. (D) A member of food and nutrition services staff. (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. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (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	{F 280}		

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{F 280}	<p>Continued From page 12</p> <p>by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents' care plans were reviewed and/or revised to reflect their current needs. This was true for 2 of 7 sample residents (#2 and #13) when the care plan did not reflect a wound vac, wound dressing, and accurate diet order. This deficient practice had the potential to cause harm if residents did not receive appropriate care and interventions due to inaccurate information on their care plans. Findings include:</p> <p>1. Resident #2 was admitted on 6/10/11 and re-admitted on 5/25/12 with multiple diagnoses including chronic multifocal osteomyelitis (infection of the bone) and MRSA (Methicillin Resistant Staphylococcus Aureus- a bacterial infection).</p> <p>Resident #2's 1/26/18 quarterly MDS assessment documented she was cognitively intact, had an open lesion other than ulcer, rash, or cut, and application of a non-surgical dressing.</p> <p>Resident #2's care plan, dated 1/11/18 documented she had MRSA in the right knee. The interventions did not address a dressing change or wound vac to the right knee. The care plan did not address a wound or dressing to the right buttock.</p> <p>Resident #2's February 2018 Medication Review Report documented dressing changes were ordered three times a week to the right knee and every 3 days to the buttocks.</p> <p>Resident #2's January 2018 Treatment Record</p>	{F 280}	<p>1. Resident #2 had the treatment plan for wound vac to right knee added to care plan on 2/07/18 and treatment for right buttock to apply Mepilex dressing until healed was added to the care plan on 2/07/18. Resident # 13 had correct diet added to the care plan on 2/08/18.</p> <p>2. All resident care plans will be maintained with the most recent orders, treatment changes, etc. so staff are informed of the care needs of the residents. Not all orders will be seen on care plan but will be placed on EMAR and TAR.</p> <p>3. The DNS and ADON will provide education to all care team members by 3/08/2018 regarding the importance of updating the care plan as changes occur.</p> <p>4. List of new physician orders will be reviewed by the DNS or designee daily, Monday through Friday, weekend orders will be reviewed on Monday mornings. The DNS or designee will audit those care plans to assure new orders are addressed. This audit will be done weekly X4 and then monthly X3. The DNS or designee will report audit findings to the QAPI committee monthly and the committee will determine if further auditing is needed.</p>		

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{F 280}	<p>Continued From page 13</p> <p>documented a dressing change was to be done on 1/12 and 1/15/18, and "125 mmHG (millimeters of mercury) negative pressure continuous" (from a wound vac). A wound vac was in place to the right knee and a dressing change was to be done three times a week for two weeks on Monday, Wednesday, and Friday starting 1/19/18 at 4:00 pm until 1/31/18 at 11:59 PM.</p> <p>Resident #2's February 2018 Treatment Record documented a dressing change was to be done every 3 days and as needed to the buttocks, starting 2/2/18 at 7:30 PM. A dressing change was to be done to the right knee three times a week for two weeks on Monday, Wednesday, and Friday starting 2/2/18 at 6:00 AM until 2/16/18 at 11:59 PM.</p> <p>On 2/6/18 at 10:26 AM, Resident #2 had a dressing and wound vac in place to her right knee. The resident said the dressing was last changed on 2/4/18, she had been going to the wound clinic, and her next appointment at the wound clinic was scheduled for 2/14/18.</p> <p>On 2/7/18 at 9:20 AM, Resident #2 said she had a wound on her buttock and the wound nurse was putting ointment on it once a week.</p> <p>On 2/7/18 at 10:35 AM, the DON said the wound vac and dressing change to the buttock should be on Resident #2's care plan and there was "room for improvement" on the care plan.</p> <p>2. Resident #13 was admitted on 1/9/18 with multiple diagnoses including nausea with vomiting, malignant neoplasm (cancer), and</p>	{F 280}			

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{F 280}	<p>Continued From page 14</p> <p>GERD (Gastroesophageal Reflux Disease-a stomach acid problem).</p> <p>Resident #13's 1/16/18 Admission MDS assessment documented he was cognitively intact and had a feeding tube, mechanically altered diet, and therapeutic diet while a resident.</p> <p>Resident #13's care plan, initiated on 1/11/18 and revised on 1/13/18, documented he had nutritional problems or potential for nutritional problems exhibited by diagnosis of cancer, approximately 45 pound weight loss, and swallowing problems due to radiation burns of the esophagus. The interventions documented a "Fortified diet, Regular Texture, Regular Fluids. Cut up meats..."</p> <p>Resident #13's January 2018 Medication Review Report documented a "Special diet Level 3-Advanced texture...Clarify oral diet as Fortified Level 3."</p> <p>Resident #13's February 2018 Medication Review Report documented a "Special diet Special texture...Clarify diet to Fortified Level 4. Meats cut into small pieces. Extra gravy and dressing..."</p> <p>The Idaho Diet Manual, 2015, defined a Level 3 Advanced diet as "Solid textures. Requires more chewing ability. Includes soft, chopped easy-to-cut meats, fruits, and vegetables. Excludes hard, crunchy fruits & vegetables, sticky foods, and very dry foods."</p> <p>The Idaho Diet Manual, 2015, defined a Level 4 diet as "Any solid texture."</p>	{F 280}			

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{F 280}	Continued From page 15 A facility fax to the physician on 1/11/18 at 12:44 PM documented a request to clarify Resident #13's diet as "Fortified Level 3." The physician responded "OK" on 1/12/18. An "Order Details" document, dated 1/21/18 at 2:43 PM, documented an order for a Level 3-Advanced texture diet. On 2/6/18 at 2:45 PM, Resident #13 was eating in his room. The meal tray included meatloaf, a baked potato with butter, cooked broccoli, a bread roll, and red Jello with pear slices that were approximately 2 to 2 and one-half inches long. The meal ticket on the tray documented "Mechanical, Regular." Approximately halfway down the page on the meal ticket was handwritten "Reg extra butter." On 2/7/18 at 2:45 PM, the DON said it looked like the resident had a mechanical soft diet. The CDM (Certified Dietary Manager) said Resident #13's diet was just advanced to a Regular diet and it was not updated in the computer yet. Resident #13's care plan documented he was on a Regular diet on 1/11/18. The resident's orders documented he was on a special diet in January and February 2018. The level 4 (regular texture) diet was not ordered until 2/2/18.	{F 280}			
{F 281} SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility,	{F 281}		3/9/18	

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{F 281}	<p>Continued From page 16 as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, it was determined the facility failed to meet professional standards of practice for 4 of 7 sample residents (#s 1, 2, 10, and 13). This was true when:</p> <ul style="list-style-type: none"> * Pulse and blood pressure were not monitored for a resident with A-fib. * Oxygen saturation (the percentage of oxygen in the blood) was not appropriately monitored for a resident receiving oxygen and low oxygen saturation readings were not appropriately addressed. * Oxygen, pulse and blood pressure medication orders lacked parameters regarding when to hold the medication and when to notify the physician. * Physician's orders were not followed regarding giving a medication via the correct route, holding blood pressure medication, and monitoring a resident's pulse and lung sounds before and after a respiratory medication. <p>This failure created the potential for harm should residents experience a decline in their health. Findings include:</p> <p>1. Resident #13 was admitted on 1/9/18 with multiple diagnoses including nausea with vomiting, malignant neoplasm (cancer), GERD,</p>	{F 281}	<p>1. Resident #13 physician orders will be followed regarding the route in which medications will be given. The resident will have pre and post pulse checks and breath sounds with use of nebulizer medications, this will be noted on the eMAR.</p> <p>Resident #10 will have B/P checked and parameters followed with use of blood pressure medications. Abnormal readings will be reported to Aspen hospice weekly as per their instructions.</p> <p>Resident #2 will have B/P checked prior to medication administration and parameters will be followed per physician orders. Oxygen levels were reported to MD who ordered continuous oxygen.</p> <p>Resident #1 eMAR now reflect the need for pulse and B/P monitoring prior to administering Amiodarone. Notification parameters to be followed per doctor's orders but physician did not request hold orders for this medication.</p> <p>2. All residents receiving medications or have conditions that require vital sign, oxygen levels, and blood glucose level monitoring and parameters will have these noted on the eMARs so that nursing staff will know if/when a medication should be held or changed.</p>		

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{F 281}	<p>Continued From page 17</p> <p>acute respiratory failure, pulmonary edema (inflammation of the respiratory system), and emphysema.</p> <p>a. The facility's Medication Administration Policy and Procedure, revised 10/17, documented "Follow the "Six Rights:" Right Medication, right dose, right resident, right route, right time and right documentation."</p> <p>Resident #13's care plan documented the following:</p> <p>* The resident had radiation therapy related to lung cancer.</p> <p>* Interventions initiated on 1/13/18 included monitoring, documenting, and reporting to the health care provider as needed for radiation treatment complications or side effects, including "...nausea/vomiting...stomatitis (inflammation of the mouth)...heartburn...swallowing problems...sore throat..." and "The resident has radiation burns to his esophagus, and has swallowing problems from radiation burns."</p> <p>Resident #13's January 2018 MAR documented Guaifenesin tablet (an expectorant to help with excess mucous) 600 mg (milligrams) by mouth twice a day was ordered on 1/9/18, given on 1/10 and 1/11/18, and was discontinued on 1/11/18. The MAR documented Guaifenesin tablet 600 mg by PEG tube twice a day was ordered on 1/11/18 and was given on 1/11-1/31/18.</p> <p>A Daily Skilled Note, dated 1/13/18 at 9:52 PM, documented Resident #13 tried to take oral medication at bedtime with success. There were</p>	{F 281}	<p>3. The DNS and ADON will educate nursing staff by 3/08/2018 regarding the need to have complete medication/treatment orders with parameters included, to have these parameters reflected on the eMAR and eTAR, and what each physician's expectations as to notifications of abnormal readings and that each resident will have resident specific parameters per MD orders.</p> <p>4. New physician orders will be reviewed daily Monday through Friday, weekend orders will be reviewed Monday morning by DNS or designee. The DNS or designee will audit that all orders needing vital sign, BG level, oxygen level parameters will have these included in the physician order. These parameters will be reflected on the eMAR/TAR and the physician's expectations as to when abnormal findings are reported. This audit will be done weekly X4 and then monthly X3. The audit findings will be reported to the QAPI committee monthly and the committee will determine if further auditing is needed.</p>		

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{F 281}	<p>Continued From page 18</p> <p>no active orders at this time for any medications to be given by mouth.</p> <p>Resident #13's February 2018 MAR documented the Guaifenesin tablet was given by PEG tube on 2/1 through 2/6/18.</p> <p>On 2/6/18 at 2:30 PM, Resident 13 said he still takes some pills by mouth that can't go down the PEG tube and he described a large pill to help with mucous. The resident said it had not been discussed with him regarding how he should take his pills.</p> <p>On 2/6/18 at 2:55 PM, LPN #1 said the resident was currently taking Guaifenesin by mouth and the order was to give the medication by PEG tube. LPN #1 said the Guaifenesin tablet could not be given through the PEG tube and they should obtain a new order to change the form of Guaifenesin or change the route to oral. LPN #1 said the Guaifenesin should not be given by mouth at this time according to the current order.</p> <p>b. The facility's Nebulizer Policy and Procedure, revised 9/2015, documented the following:</p> <p>* "Note pre-treatment data such as pulse and breath sounds..."</p> <p>* "Note post-treatment data (pulse, breath sounds and any side effects) and record in the medical record..."</p> <p>Resident #13's care plan documented he had emphysema exhibited by shortness of breath and oxygen use. The care plan directed staff to monitor for signs and symptoms of respiratory</p>	{F 281}			

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{F 281}	<p>Continued From page 19 distress and report to the health care provider.</p> <p>Resident #13's January 2018 MAR documented Duoneb Solution (a breathing medication given by nebulizer) 0.5-2.5 (3) MG/3ML (milliliters) inhale four times a day was ordered on 1/9/18. The Duoneb was given on 1/10-1/31/18. There was no documentation the resident's pulse or respiratory status was assessed before or after the Duoneb.</p> <p>Resident #13's February 2018 Medication Review Report documented Duoneb Solution 0.5-2.5 (3) MG/3ML inhale four times a day, document pulse and lungs sounds pre and post administration, and record the total time nursing spent with the resident.</p> <p>Resident #13's February 2018 MAR documented the Duoneb Solution was given on 2/1 through 2/6/18. There was no documentation the resident's pulse or respiratory status was assessed before or after the Duoneb.</p> <p>On 2/7/18 at 11:15 AM, the DON said the pulse and respiratory status should be documented on Resident #13's MAR with the Duoneb administration and it was not documented.</p> <p>2. Resident #10 was admitted on 10/5/17 with multiple diagnoses including CHF (Congestive Heart Failure) and hypertension (high blood pressure).</p> <p>Resident #10's care plan and medication orders did not document directions to monitor blood pressure or parameters regarding when to hold blood pressure medication and when to report</p>	{F 281}			

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{F 281}	<p>Continued From page 20 out of range blood pressures to the physician.</p> <p>Resident #10's MARs documented the following:</p> <ul style="list-style-type: none"> * Lisinopril (blood pressure medication) 2.5 mg tablet was given each bedtime from 12/29/17-1/4/18. * Coreg was given each day from 12/29/17-1/31/18. * Entresto was given each day from 1/8-1/31/18, except for the bedtime dose on 1/8 and 1/18, and the AM dose on 1/15 when the medication was not available. * Coreg and Entresto were given each day from 2/1/18-2/6/18. <p>The resident's clinical record did not document her blood pressure was consistently monitored prior to administering blood pressure medications.</p> <p>On 2/7/18 at 11:45 am, the DON said the blood pressure should be checked prior to giving blood pressure medication, and parameters should be documented regarding when to hold blood pressure medication and when report out of range blood pressures to the physician.</p> <p>3. Resident #2 was admitted on 6/10/11 and re-admitted on 5/25/12 with multiple diagnoses essential hypertension (high blood pressure).</p> <p>a. Resident #2's hypertension care plan, initiated 4/25/17, directed staff to monitor, document, report to health care provider as needed for any</p>	{F 281}			

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{F 281}	<p>Continued From page 21</p> <p>signs/symptoms of malignant hypertension (e.g., headache, visual problems, confusion, disorientation, lethargy, nausea and vomiting, irritability, seizure activity, difficulty breathing).</p> <p>Resident #2's February 2018 Medication Review Report, documented the following:</p> <ul style="list-style-type: none"> * Diltiazem (blood pressure medication) tablet 30 mg via PEG tube was ordered on 12/5/17 * Hold the medication if blood pressure less than 100 systolic (top number) or less than 60 diastolic (bottom number). <p>Resident #2's January 2018 MAR documented the diltiazem was given 18 times out of 93 opportunities when the diastolic blood pressure was less than 60</p> <p>Resident #2's February 2018 MAR documented the diltiazem was given 1 time out of 17 opportunities when the diastolic blood pressure was less than 60.</p> <p>On 2/7/18 at 10:00 AM, the DON said the facility uses blood pressure parameters according to the American Heart Association, and she would expect the nurse to notify the physician if the resident's blood pressure was less than 100/60 or greater than 140/90. The DON said the nurse should not have given the diltiazem when the diastolic blood pressure was less than 60.</p> <p>b. According to the National Institutes of Health (7/16/15), a pulse oximetry reading (a device that measures the percentage of oxygen saturation in the blood) of less than 90 indicates hypoxemia (a</p>	{F 281}		

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{F 281}	<p>Continued From page 22 low oxygen level).</p> <p>Resident #2's altered respiratory status care plan documented oxygen therapy at 2 liters by nasal cannula (tubing) with humidity at bedtime was initiated on 11/9/17. The care plan interventions, initiated 4/25/17, directed staff to monitor for signs and symptoms of respiratory distress and report to health care provider as needed regarding "increased respirations, decreased pulse oximetry, increased heart rate (tachycardia)..."</p> <p>Resident #2's February 2018 Medication Review Report documented oxygen at 2 liters per minute via nasal cannula at "bedtime for Desaturation" (decreased oxygen level in the blood) was ordered on 11/4/17. There were no parameters ordered regarding when to monitor the resident's oxygen level and when to notify the physician of abnormal oxygen saturation levels.</p> <p>Resident #2's MARs or Treatment Records did not document the oxygen being administered at bedtime. The Nursing Notes did not document assessment of her respiratory status.</p> <p>Resident #2's Weights and Vitals Summary, dated 12/29/17-2/7/18, documented her oxygen saturation was checked, on average, once a day between 6:30 and 10:30 AM with occasional gaps of one to three days between checking the oxygen saturation. Resident #2's oxygen saturation was less than 90% on room air during waking hours on 4 of 26 documented occasions.</p> <p>On 2/7/18 at 10:20 AM, the DON said she would expect staff to check Resident #2's oxygen</p>	{F 281}			

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{F 281}	<p>Continued From page 23</p> <p>saturation daily when the oxygen was on at night to see if her oxygen level decreased, that staff could put oxygen back on the resident if the oxygen saturation was less than 90% and should notify the physician. The DON said Resident #2's orders were not complete and the orders should include checking the oxygen saturation and to place oxygen on the resident as needed if her oxygen saturation was less than 90%.</p> <p>4. Resident #1 was admitted to the facility on 6/13/14 with multiple diagnoses including atrial fibrillation and hypertension.</p> <p>The facility's blood pressure medication policy, dated 2013, directed staff to check blood pressure and pulse for residents taking Amiodarone.</p> <p>Resident #1's January and February 2018 Medication Review Report documented an order, dated 4/21/15, for Amiodarone 200 mg by mouth one time a day for atrial fibrillation. There were no parameters for holding the medication or notify the physycian when the pulse and blood pressure were outside expected range.</p> <p>The Centers for Disease Control and Prevention and American Heart Association has classified high blood pressure as systolic (top number) was 140 mmHg or higher and diastolic (bottom number) was 90 or higher. A normal pulse rate was 60-100.</p> <p>Between 1/1/18 and 2/7/18, on 7 out of 38 days pulse rates ranged from 54 to 59 and 12 out of 38 days no pulses were documented on Resident #1's pulse and on 20 out of 38 days the blood pressures documented on the MAR ranged from</p>	{F 281}			

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

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{F 281}	<p>Continued From page 24 142/68 to 157/86. The MAR documented Resident #1 received Amiodarone 38 out of 38 opportunities.</p> <p>On 2/6/18 at 4:15 PM and 2/7/18 at 9:50 AM, the DON said Resident #1's Amiodarone order should have directed staff regarding pulse and blood pressure parameters. She said as a standard of practice, she would expect staff to check the resident's pulse and blood pressure prior to giving the medication, to hold the medication when the pulse was under 60, or when systolic blood pressures were higher than 140 or diastolic blood pressures were lower than 60 and to contact the physician for further direction.</p> <p>On 2/7/18 at 10:45 AM, RN #1 said she checked Resident #1's pulse and blood pressure prior to giving the medication and said there were no parameters on the order.</p> <p>On 2/8/18, the facility provided additional information by the pharmacist. The Amiodarone package insert documented parameters should include monitoring of resident's blood pressure, heart rate and rhythm.</p>	{F 281}		