



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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February 24, 2020

Jamie Berg, Administrator
Good Samaritan Society - Moscow Village
640 North Eisenhower Street
Moscow, ID 83843-9588

Provider #: 135067

Dear Ms. Berg:

On **February 6, 2020**, a survey was conducted at Good Samaritan Society - Moscow 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 a widespread deficiency 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.

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 5, 2020**. Failure to submit an acceptable PoC by **March 5, 2020**, may result in the imposition of penalties by **March 28, 2020**.

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

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

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

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 12, 2020 (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 **May 6, 2020**. A change in the seriousness of the deficiencies on **March 22, 2020**, 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 **May 6, 2020** includes the following:

Denial of payment for new admissions effective **May 6, 2020**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 6, 2020**, 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 Belinda Day, RN or Laura Thompson, RN, 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 **May 6, 2020** 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

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be found on the Internet at:

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

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

- BFS Letters (06/30/11)

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

This request must be received by **March 5, 2020**. If your request for informal dispute resolution is received after **March 5, 2020**, 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 Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Belinda Day, RN , Supervisor
Long Term Care Program

bd/dr

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

PRINTED: 03/13/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/06/2020
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOSCOW VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 640 NORTH EISENHOWER STREET MOSCOW, ID 83843		
(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 February 3, 2020 through February 6, 2020. The surveyors conducting the survey were: Jenny Walker, RN, Team Coordinator Kim Saccomando, RN Linda Zuschlag, RN Abbreviations: CM = Case Manager DNS = Director of Nursing LPN = Licensed Practical Nurse mcg = micrograms MDS = Minimum Data Set mg = milligrams RN = Registered Nurse SSD = Social Services Director	F 000			
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is	F 622		3/12/20	

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

TITLE

(X6) DATE

Electronically Signed

03/05/2020

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 622	<p>Continued From page 1</p> <p>endangered due to the clinical or behavioral status of the resident;</p> <p>(D) The health of individuals in the facility would otherwise be endangered;</p> <p>(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid;</p> <p>or</p> <p>(F) The facility ceases to operate.</p> <p>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.</p> <p>§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(i) Documentation in the resident's medical</p>	F 622			

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F 622	Continued From page 2 record must include: (A) The basis for the transfer per paragraph (c) (1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c) (2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, policy review, and record review, it was determined the facility failed to ensure information was provided to the receiving facility when a resident was discharged for of 1 of 2 residents (Resident #46) reviewed	F 622	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		

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F 622	<p>Continued From page 3</p> <p>for transfer and discharge. This deficient practice had the potential to cause harm if the resident did not receive the appropriate care and services in a timely manner due to the lack of information. Findings include:</p> <p>The facility's policy for transfer and discharge of patients, revised on September 2017, stated when a facility-initiated transfer of a resident occurred, the appropriate transfer information was communicated to the receiving healthcare center. It stated the minimum information provided to the receiving facility included:</p> <ul style="list-style-type: none"> * contact information for the medical practitioner responsible for care * resident representative information * advance directive information * all instructions for ongoing care * comprehensive care plan goals * a copy of the discharge summary <p>This policy was not followed.</p> <p>Resident #46 was admitted to the facility on 9/1/19, with multiple diagnoses including fractures of the spine, pelvis, and right elbow.</p> <p>A discharge MDS assessment, dated 11/5/19, documented Resident #46 was discharged to the community and return was not anticipated.</p> <p>Resident #46's record did not include documentation of the transfer or discharge. There was no documentation by the physician the resident was discharged.</p> <p>On 2/6/20 at 3:39 PM, Case Manager #1 stated</p>	F 622	<p>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 the State Operations Manual.</p> <ol style="list-style-type: none"> 1. NA - Resident #46 is discharged. 2. Progress notes on all residents discharged since January 1, 2020, will be reviewed to identify specific training needs. 3. The QAPI Team determined the root cause of the deficiency was not documenting in a discharge progress note that we provided information for an internal transfer to our assisted living facility. The facility created an internal discharge checklist in which the licensed nurses and care team will be educated. 4. The DNS or designee will audit all discharges for discharge progress notes weekly X 4 and monthly X 2. All findings will be reported to the QAPI Committee for further monitoring and modification. 		

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F 622	Continued From page 4 the facility did not have a discharge meeting for Resident #46. She stated on 10/31/19, the facility was told by Physical Therapy Resident #46 was ready for discharge from the facility to an assisted living facility. She stated the facility called the assisted living facility 24 hours after transfer to answer questions. She stated the facility did not give a discharge report. On 2/6/20 at 4:00 PM, the DNS stated there was no discharge note. He stated his expectation was Resident #46 should have had a discharge note including who accompanied him, when he left, and how he was discharged. He stated that information should have been written in the progress note and it was not. On 2/6/20 at 4:15 PM, the SSD stated there was no notification for transfer or discharge in Resident #46's record. The SSD provided a transfer/discharge form that was to be completed on every resident on discharge or transfer which addressed the information needed by a receiving facility. The SSD stated Resident #46's record did not include the transfer/discharge form.	F 622			
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.	F 623		3/12/20	

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F 623	<p>Continued From page 5</p> <p>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights,</p>	F 623			

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F 623	<p>Continued From page 6</p> <p>including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and</p> <p>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the</p>	F 623			

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F 623	<p>Continued From page 7</p> <p>State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, policy review, and record review, it was determined the facility failed to ensure a transfer notice was provided to the resident, the resident's representative, and the Office of the State Long-Term Care Ombudsman for 1 of 2 residents (Resident #46) reviewed for transfer and discharge. This deficient practice had the potential to cause harm if residents were not made aware of or able to exercise their rights related to transfers. Findings include:</p> <p>The facility's policy for transfer and discharge of patients, revised September 2017, stated the facility notified the resident and the resident's representative of the transfer and the reason for the transfer in writing. It also stated, when the facility initiated a transfer or discharge, the facility sent a copy of the transfer or discharge form to a representative of the Office of the State Long-Term Care Ombudsman.</p> <p>This policy was not followed.</p> <p>Resident #46 was admitted to the facility on 9/1/19, with multiple diagnoses including fractures of the spine, pelvis, and right elbow.</p> <p>A discharge MDS assessment, dated 11/5/19, documented Resident #46 was discharged to the community and return was not anticipated.</p>	F 623	<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 the State Operations Manual.</p> <ol style="list-style-type: none"> 1. Resident #46 was provided and signed a Notification of Transfer or Discharge on February 12, 2020. The Notification was scanned and downloaded to the Ombudsman reporting portal on February 12, 2020. 2. All residents transferred or discharged in 2020 will have their records reviewed for a Notification of Transfer and Discharge as well as an Ombudsman notification. Any outstanding Notifications of Transfer and Discharge will be sent to the Ombudsman. 		

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F 623	Continued From page 8 Resident #46's record did not include documentation the notification of transfer or discharge was given to Resident #46, his representative, and to the Office of the State Long-Term Care Ombudsman. On 2/6/20 at 4:15 PM, the SSD stated there was no notification of the transfer or discharge in Resident #46's record. She stated the facility had a notification of transfer or discharge form, but Resident #46 did not have one completed. She stated the facility only sent notification to the Ombudsman via their online portal when there was a concern the resident did not want to be discharged.	F 623	3. The QAPI Team determined that the root cause of the deficiency was not notifying the Ombudsman on internal transfers to a lower level of care, specifically to our Good Samaritan Assisted Living facility. Social Services will be re-educated on the Discharge and Transfer Policy and Procedure. 4. The Social Services Director or designee will audit all discharges weekly X 4 and monthly X 2. All findings will be reported to the QAPI Committee for further monitoring and modification.		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure care plans related to dialysis care and services were implemented and post-dialysis assessments were completed. This was true for 1 of 1 resident (Resident #146) who was reviewed for dialysis. This failure created the potential for harm if Resident #146 experienced complications and/or compromised medical status. Findings include: Resident #146 was admitted to the facility on	F 698	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,	3/12/20	

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F 698	Continued From page 9 1/21/20, with multiple diagnoses including end stage renal disease. Resident #146's dialysis care plan, dated 1/21/20, documented he received hemodialysis (a treatment to remove fluid and waste products from the blood) on Monday, Wednesday, and Friday at a local dialysis center. The care plan directed licensed staff to monitor and report for signs and symptoms of infection to his access site including redness, swelling, warmth or drainage. Resident #46's record did not include documentation what type of dialysis access site he had, how to monitor, care, or assess the dialysis access site, or to complete a post-dialysis resident assessment. On 2/6/20 at 2:55 PM, Resident #146 stated his access site was located to his right upper chest. Resident #146 lifted his shirt and he had a central line (a small, soft tube placed in a vein that leads to the heart) that was covered with a dressing to his right upper chest. The DNS and CM #1 were present during the observation On 2/6/20 at 3:05 PM, the DNS stated Resident #146's record did not include post dialysis assessments, which should have documented his vital signs, monitoring of the access site, and a post dialysis weight. The DNS stated Resident #146's record did not include where his access site was located and directions for the licensed staff to assess Resident #146 when he returned from dialysis.	F 698	this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual. 1. Resident #146's care plan was updated to include the type of dialysis access site. Post-dialysis assessments were initiated. 2. NA - No other residents are receiving dialysis. 3. The QAPI Team determined the root cause of the deficiency was the infrequent number of dialysis residents who reside in our center and the lack of a checklist when a new dialysis resident is admitted. An internal checklist will be created for new residents on dialysis and the licensed nurses and care team will be educated on the checklist. 4. The DNS or designee will audit post dialysis documentation on all dialysis residents and the care plans on new dialysis residents weekly X 4 and monthly X 2.		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)	F 759		3/12/20	

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F 759	<p>Continued From page 10</p> <p>§483.45(f) Medication Errors. The facility must ensure that its-</p> <p>§483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure the medication error rate was less than 5% for 4 of 39 medication opportunities, which was an error rate of 10.26%. This affected 2 of 6 residents (#24 and #196) whose medication administration was observed. This failed practice placed residents at risk of not receiving medications as ordered by their physician and had the potential to affect the therapeutic levels and effectiveness of the medications administered. Findings include:</p> <p>According to the U.S. Food and Drug Administration (FDA) website, fda.gov, accessed 2/11/20, taking medications at the correct time and frequency is important because if not it could lead to worsening of disease, hospitalization, or an adverse event.</p> <p>The Nursing 2019 Drug Handbook stated the eight rights of medication administration were right drug, right patient, right dose, right time, right route, right reason, right response, and right documentation. The handbook stated to ensure the drug was administered at the correct time and frequency.</p> <p>The facility's Medication Administration policy, revised January 2020, documented medications</p>	F 759	<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 the State Operations Manual.</p> <p>1. a. The medications for resident #196 were located and administered at the next medication pass. An incident report was completed and the family and physician were notified. b. Resident #24's medication was received and given beginning at the a.m. medication pass on February 6, 2020. An incident report was completed and the family and physician were notified.</p> <p>2. All residents' Medication Administration Records (MARs) will be</p>		

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F 759	<p>Continued From page 11 must be administered within 1 hour on each side of the ordered time.</p> <p>This policy was not followed.</p> <p>a. Resident #196 was admitted to the facility on 1/28/20, with multiple diagnoses including respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood), restless leg syndrome (a condition that causes an uncontrollable urge to move your legs), pain, and idiopathic neuropathy (nerve damage of unknown origin).</p> <p>Resident #196's Order Summary Report included the following medications:</p> <ul style="list-style-type: none"> * Pramipexole (a medication that treats restless leg syndrome), 1 mg orally two times a day. * Pregabalin (medication to treat neuropathy which is a disease or dysfunction of one or more peripheral nerves, typically causing numbness or weakness), 25 mg orally in the morning. * Spiriva Capsule (medication that relaxed muscles in the airways and increased air flow to the lungs), 18 mcg to be inhaled orally daily. <p>On 2/5/20 at 8:47 AM, RN#1, was observed administering medication to Resident #196. The Pramipexole, Pregabalin and Spiriva morning medication doses which were ordered to be administered to Resident #196 were not found by RN #1. Resident #196 did not receive her medications as ordered and her physician was not notified of the missed doses.</p> <p>b. Resident #24 was admitted to the facility on 2/17/19, with multiple diagnoses including</p>	F 759	<p>reviewed for the medication code "not available." Incident reports will be completed on all omitted medications per GSS Policy and Procedure.</p> <p>3. The QAPI Team determined the root cause of the deficiency was not following up on medications that were not available. A protocol was created to guide nurses on how to respond to unavailable medications. All licensed nurses will be educated on the protocol.</p> <p>4. The DNS or designee will audit the MARs for medications not given/unavailable weekly X 4 and monthly X 2. All findings will be reported to the QAPI Committee for further monitoring and modification.</p>		

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F 759	Continued From page 12 dementia, pain, glaucoma (a disease that damages the eye's nerve, causing blindness due to fluid buildup in the eye), and anxiety. Resident #24's Order Summary Report documented Muro 128 ointment 5% (used for glaucoma) to be administered in both eyes four times a day. On 2/5/20 at 8:47 AM, RN #1 stated Resident #24's Muro ointment was not available and did not administer the medication. She did not contact the physician or pharmacy for the missed dose. On 2/5/20 at 2:30 PM, CM #1 stated missing medications were faxed into the pharmacy or ordered on the computer from the pharmacy. She stated when medications were unavailable, she expected the nurse to call the pharmacy and notify the physician of the missed medication dose.	F 759			
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, food test tray evaluation, and policy review, it was	F 804	Preparation and Execution of this response and plan of correction does not	3/12/20	

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F 804	<p>Continued From page 13</p> <p>determined the facility failed to ensure food was palatable and served at a safe and appetizing temperature to the residents. This had the potential to effect the 44 residents who resided in the facility who consumed meals prepared in the facility's kitchen. This failed practice had the potential to negatively impact residents' nutritional status. Findings include:</p> <p>The facility's Food Temperature Monitoring policy, revised June 2019, documented the food temperatures were to be taken and recorded before each meal service and at other times to ensure temperatures were held within acceptable ranges.</p> <p>This policy was not followed.</p> <p>On 2/5/20 at 11:30 AM, Cook #1 began serving the meal without checking temperatures of the food items being served off the tray line. Cook #1 did not check the temperatures of the chicken, the ground pork, one of the two gravies, and the mixed vegetables. Cook #1 continued to plate meals until the Registered Dietitian (RD) asked Cook #1 if the temperatures of the food on the tray line were checked. Cook #1 stated he had not checked any temperatures of the food on the tray line because he did not have time. The RD instructed Cook #1 to check the temperatures of the food before continuing to plate food.</p> <p>On 2/5/20 at 11:33 AM, Cook #1 checked the food temperatures on the tray line. The top of the thermometer, that displayed the digital temperature, was placed in the mixed vegetables. The temperature of the mixed vegetables was 113.7 degrees Fahrenheit. The</p>	F 804	<p>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 the State Operations Manual.</p> <ol style="list-style-type: none"> 1. The cook was counselled regarding food temperatures and monitoring. 2. All residents who are served from the kitchen have the potential to be affected. 3. The QAPI Team determined that the root cause of the deficiency was the cook not following the policies and procedures. Cooks will be re-educated on the policies and procedures on Food Temperature Monitoring and Food Thermometers. 4. The Director of Food & Nutrition or designee will audit the tray line daily X 5, weekly X 3 and monthly X 2. Results will be reported to the QAPI Committee for further monitoring and modification. 		

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F 804	Continued From page 14 Director of Food Service removed the mixed vegetables from the tray line to reheat them. The Director of Food Service stated Cook #1 failed to check food temperatures prior to food service. The Director of Food Service stated the temperature of the vegetables should have been at least 135 degrees Fahrenheit. On 2/5/20 at 11:35 AM, Cook #1 completed checking food temperatures on the foods being served from the tray line. One tray that was prepared prior to the temperatures being checked remained on the rack that was to be delivered to the 600 unit. On 2/5/20 at 11:45 AM, the lunch meal rack with trays for the 600 unit left the kitchen. The RD and the surveyor followed the rack with the lunch trays to the 600 Unit. On 2/5/20 at 11:55 AM, the tray for the 600 unit was tested for temperature and taste. The chicken temperature was 105 degrees Fahrenheit and the broccoli temperature was 106.1 degrees Fahrenheit. The RD stated the food was not hot to taste.	F 804			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		3/12/20	

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F 812	<p>Continued From page 15</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, and policy review, it was determined the facility failed to provide safe and sanitary food handling and distribution for the residents who received dietary services from the facility's kitchen and had the potential to affect all 44 residents in the facility. This failed practice had the potential to expose residents to food borne illness.</p> <p>The facility's Food Handling policy, revised July 2018, documented the purpose was to limit contamination of food served to a highly susceptible population. The food was to be handled in a manner that minimized the risk of contamination.</p> <p>This policy was not followed.</p> <p>On 2/5/20 at 11:30 AM, Cook #1 checked the food temperatures on the tray line and placed the thermometer in the mixed vegetables, covering the entire thermometer with his fingers touching the mixed vegetables. Cook #1 then removed the thermometer by putting his hand in the mixed vegetables to remove it. The Director of Food</p>	F 812	<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 the State Operations Manual.</p> <ol style="list-style-type: none"> 1. The cook was counselled regarding food safety. 2. All residents who are served from the kitchen have the potential to be affected. 3. The QAPI Team determined that the root cause of the deficiency was the cook 		

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F 812	Continued From page 16 Service stated the mixed vegetables were contaminated. On 2/5/20 at 11:33 AM, Cook #1 was observed serving the pork chops by using tongs and the tongs touched Cook #1's apron and the outside of the steam table. The Surveyor intervened, stating the tongs were contaminated. The Director of Food Services stopped Cook #1 and replaced the contaminated tongs with a clean pair. The Director of Food Services stated Cook #1 contaminated the first set of tongs when it touched his apron and the outside of the steam table.	F 812	not following the policies and procedures. Cooks will be re-educated on the policies and procedures on Food Handling and Food Thermometers. 4. The Director of Food & Nutrition or designee will audit the tray line daily X 5, weekly X 3 and monthly X 2. Results will be reported to the QAPI Committee for further monitoring and modification.		