



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN – Director

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

April 11, 2019

Craig Perez, Administrator
Good Samaritan Society - Idaho Falls Village
840 East Elva Street
Idaho Falls, ID 83401-2899

Provider #: 135092

Dear Mr. Perez:

On **March 29, 2019**, a survey was conducted at Good Samaritan Society - Idaho Falls Village by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 22, 2019**. Failure to submit an acceptable PoC by **April 22, 2019**, may result in the imposition of penalties by **May 14, 2019**.

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 **May 3, 2019 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **June 29, 2019**. A change in the seriousness of the deficiencies on **May 13, 2019**, may result in a change

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in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 29, 2019** includes the following:

Denial of payment for new admissions effective **June 29, 2019**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 29, 2019**, 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 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. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **June 29, 2019** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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<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 **April 22, 2019**. If your request for informal dispute resolution is received after **April 22, 2019**, 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: 04/25/2019
FORM APPROVED
OMB NO. 0938-0391

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| 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 03/29/2019 |
| 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 during the federal recertification and complaint survey conducted at the facility from March 25, 2019 to March 29, 2019. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Carmen Blake, RN Survey Abbreviations: CNA = Certified Nursing Assistant CPR = Cardiopulmonary Resuscitation DNR = Do Not Resuscitate DON = Director of Nursing LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment POST = Physician Order for Scope of Treatment RN = Registered Nurse | F 000 | | | |
| F 550 SS=D | Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. | F 550 | | 4/30/19 | |

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

TITLE

(X6) DATE

Electronically Signed

04/21/2019

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 550 | Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, it was determined the facility failed to maintain or enhance residents' dignity during dining when residents seated at the same table were served their meals at different times. This was true for 2 of 3 residents (#30 and #143) reviewed for dignity. This failure had the potential to cause psychosocial harm due to a decrease in residents' sense of self-worth and psycho-social well-being. Findings include: | F 550 | 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 center is not in substantial compliance | | |

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| F 550 | <p>Continued From page 2</p> <p>a. On 3/25/19 at 5:10 PM, Resident #30 arrived in his wheelchair in the dining room at the table where two other residents were seated. A few minutes later, the other two residents received their meals and began to eat. At 5:23 PM, one of the other residents had finished her meal and left the dining room. At 5:24 PM, Resident #30's meal arrived and he began to eat.</p> <p>b. On 3/26/19 at 12:10 PM, Resident #143 and one other resident were seated at the same table in the dining room. At 12:20 PM, the other resident received her meal and began to eat. At 12:28 PM, Resident #143's meal arrived and she began to eat. At 12:29 PM, one minute later, the other resident was finished with her meal and assisted out of the dining room by a staff member.</p> <p>c. On 3/26/19 at 12:23 PM, Resident #30 was seated in his wheelchair in the dining room at the same table as two other residents. At 12:23 PM, the other two residents had received their meals and began to eat. At 12:31 PM, Resident #30's meal arrived as one of the other residents finished his meal.</p> <p>On 3/27/19 at 8:37 AM, the Registered Dietician said she expected residents at the same table to be served at the same time.</p> <p>On 3/27/19 at 9:38 AM, CNA #1 said residents at the same table were to be served at the same time.</p> <p>On 3/27/19 at 9:54 AM, the Certified Dietary Manager said residents were served on a first come-first served basis and residents who were</p> | F 550 | <p>with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. POC Abbreviations: HIM = Health Information Management DSS = Director of Social Services DNS = Director of Nursing Services P/P = Policy & Procedure === F- 550 Resident Rights/Exercise of Rights</p> <ol style="list-style-type: none"> 1. It was determined that the facility failed to maintain or enhance the residents' dignity during dining when residents seated at the same table were served their meals at different times. Resident # 30 and 143 will have their meal served at the same time as table mates. 2. Identification of other residents with the potential to be affected by the same practice will be an ongoing process – at every meal. Identification will happen by dining staff and other staff members helping with serving meals when they verify that residents seated at the same table will be served at the same time; if a resident is not available when meal is served the dining staff will serve their meal as soon as possible after they arrive. 3. The DNS and dietary manager will educate all nursing and dietary staff on the importance of serving each table at the same time. If a resident arrives later the staff will provide the meal as soon as possible after the resident arrives. In | | |

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| F 550 | Continued From page 3 at the same table were expected to receive their meals at the same time. On 3/27/19 at 10:12 AM, Resident #30 said sometimes he was served after his tablemates had received their meals. | F 550 | order to accomplish this, a process change is being executed in the following manner. A CNA will be in the dining room at lunch and dinner to assist with meal delivery and beverage service. Breakfast is not included at this time as it is considered to be an "open breakfast" with a two hour window for serving with open seating and is manageable by the dietary staff alone. A facility P/P "Dignity in Dining and Dining Services Standards" will be reviewed with copies available for staff. This education will be completed by 4/30/19. 4. The DNS or designee will audit the meal service to ensure residents are served their meals at each table at the same time. If a resident arrives late the audit will include monitoring whether the resident is served timely. This audit will be done weekly X4 and then monthly X3 with the DNS or designee reporting the findings to the QAPI committee monthly, the committee will determine if further auditing is needed. 5. The facility will be in compliance on or before 04/30/2019. The Administrator or designee will ensure compliance. | | |
| F 578 SS=D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to | F 578 | | 4/30/19 | |

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| F 578 | <p>Continued From page 4</p> <p>receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.</p> <p>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).</p> <p>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure residents were provided information regarding advanced directives upon</p> | F 578 | <p>F- 578 Request/Refuse/Discontinue Treatment; Formulate Advance Directives</p> <p>1. It was determined that the facility failed to ensure residents were provided</p> | | |

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| F 578 | <p>Continued From page 5</p> <p>admission and were assisted to formulate an advanced directive, and residents' resuscitation code status was documented in their records. This was true for 2 of 7 residents (#92 and #142) whose records were reviewed for advanced directives. These failures created the potential for harm if residents did not have their decisions documented, honored, and respected when they were unable to make or communicate health care preferences. Findings include:</p> <p>The facility's advanced directives policy, dated 4/2016, documented upon admission and at each care planning meeting facility staff would inform residents of advanced directives, such as a living will, and inform them of their right to consent or refuse treatment. Physician orders would document code status and if cardiac arrest occurred, CPR would be initiated unless residents' valid code status was DNR.</p> <p>1. Resident #142 was admitted to the facility on 3/8/19, with multiple diagnoses including hypertension (high blood pressure).</p> <p>On 3/27/19, Resident #142's record was reviewed and there was no documentation she had a living will, a physician's order for code status, or a code status documented elsewhere.</p> <p>On 3/27/19 at 10:05 AM, Resident #142 said she was not sure if staff discussed advanced directives such as a living will with her. She said her code status was to be DNR.</p> <p>On 3/27/19 at 2:39 PM, RN #2 said she would check for code status on a resident's facesheet and MAR.</p> | F 578 | <p>information regarding advance directives upon admission and were assisted to formulate an advance directive, and residents' resuscitation code status was documented in their records. The facility DSS met with both residents identified in the statement of deficiencies. Resident #92 discharged to an assisted living residence three days after the survey process was completed, and chose not to formulate advance directives before leaving. Resident #142 completed a POST form, but chose not to formulate advance directives. Their code status desires were documented in their records.</p> <p>2. An audit of all current residents was performed on 3/27/19 by the facility Medical Records Director, QAPI coordinator, and DSS to see if they were provided the opportunity to formulate advance directives upon admission and at the other times identified by the company policy (upon readmission, upon change in condition, and at every care conference.) All residents who did not have progress notes showing that they have been given the opportunity to formulate advance directives were contacted and informed of their rights concerning the formulation of advance directives. Code status desires were updated in records as needed.</p> <p>3. The DNS and DSS will provide education to all nursing staff on the requirements regarding resident's rights in the formulation of Advance Directives, and code status orders. The company P/P on "Advanced Care Planning and Advanced Directives" will be reviewed.</p> | | |

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| F 578 | <p>Continued From page 6</p> <p>On 3/27/19 at 2:43 PM, LPN #1 said she would find a resident's code status in the code status book in the nurses' station, on the resident's MAR, and on the resident's facesheet. LPN #1 checked the code status book and said she could not find advanced directives or a current code status for Resident #142. LPN #1 said Resident #142 would be considered a Full Code and would be resuscitated if she experienced cardiac arrest.</p> <p>On 3/28/19 at 2:40 PM, the Administrator said Resident #142's record did not document if she had an advanced directive and/or was given information regarding formulating an advanced directive.</p> <p>On 3/28/19 at 2:54 PM, the Medical Records Director provided Resident #142's POST form which was signed and dated by the resident on 3/25/19. The Medical Records Director said the facility had been waiting on Resident #142's physician's signature on her POST form before it was updated in her record. The POST form documented her code status was DNR and it was not signed by Resident #142's physician.</p> <p>2. Resident #92 was admitted to the facility on 3/7/19, with multiple diagnoses including respiratory failure.</p> <p>Resident #92's care plan, dated 3/21/19, directed staff his code status was DNR.</p> <p>On 3/27/19, Resident #92's record was reviewed and there was no documentation he had a living will or a physician's order for code status.</p> | F 578 | <p>This education will be completed by 4/30/2019.</p> <p>4. The following audits will be performed weekly X4, and then monthly X3: The HIM Director will audit all resident charts to ensure all residents have been notified of their rights concerning the formulation of advance directives at the appropriate times, and that their desired code status is reflected in their records. The DSS will report audit findings to the QAPI committee monthly, the committee will determine if further auditing is needed.</p> <p>5. The facility will be in compliance on or before 04/30/2019. The Administrator or designee will ensure compliance.</p> | | |

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

PRINTED: 04/25/2019
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| F 578 | Continued From page 7 On 3/27/19 at 4:45 PM, the Medical Records Director said Resident 92's record lacked documentation of the resident's wishes regarding emergency medical care. On 3/27/19 at 5:00 PM, the Social Worker and the Administrator said Resident #92's record lacked documented evidence of the resident's wishes regarding emergency medical care in the event of a cardiac or respiratory arrest. The Social Worker stated Resident #92's care plan had been updated with information obtained from the resident, as she interviewed him, and he stated he did not want emergency medical care in the event of cardiac or respiratory arrest. The Social Worker said Resident #92 remained a "Full Code" due to the lack of a physician's order for a DNR code status, and he would be provided emergency medical care if needed, which was not in accordance with Resident #92's wishes. On 3/28/19 at 10:09 AM, the Medical Records Director said the facility had obtained information regarding Resident 92's wishes for no emergency medical care if he had a cardiac or respiratory arrest. She said the POST document needed a physician's signature to be implemented as an order by the facility, and it was not signed by the physician. | F 578 | | | |
| F 583 SS=E | Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes | F 583 | | 4/30/19 | |

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| F 583 | <p>Continued From page 8</p> <p>accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</p> <p>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, resident and staff interview, it was determined the facility failed to ensure residents' private health information was protected when residents' arm bracelets displayed private health information. This was true for 5 of 12 residents (#10, #38, #40, #92, and #142) reviewed for privacy. These failures created the potential for residents to experience a decreased sense of self-worth</p> | F 583 | <p>F- 583 Personal Privacy/Confidentiality of Records</p> <p>1. It was determined that the facility failed to ensure residents' private health information was protected when residents' arm bracelets displayed private health information. Resident arm bracelets were removed from residents #10, #40, #92, and #142. Resident #38</p> | | |

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| F 583 | <p>Continued From page 9</p> <p>when their confidential health information was displayed to the public. Findings include:</p> <p>The facility's dignity policy, dated 2/2017, directed staff not to display confidential clinical or personal information which could be seen by other residents and/or visitors.</p> <p>a. Resident #40 was readmitted to the facility on 3/4/19, with multiple diagnoses including anxiety.</p> <p>On 3/27/19 at 12:35 PM, Resident #40 was in her room in her wheelchair and had a purple bracelet which documented "DNR" and a yellow bracelet which documented "FALL RISK" on her right wrist. Resident #40 said she had both bracelets on since she was admitted to the facility and did not like them. She said her code status was DNR and said she had fallen in the past but had not fallen in the facility. Since her admission, Resident #40 had the arm bracelets on for 23 days.</p> <p>b. Resident #38 was admitted to the facility on 2/26/19, with multiple diagnoses including kidney failure.</p> <p>On 3/25/19 at 4:20 PM, Resident #38 was in her room in her wheelchair and had a pink bracelet which documented "Restricted Extremity" and a yellow bracelet which documented "FALL RISK" on her left wrist. Resident #38 said she was not sure why she had the restricted bracelet on and she had not fallen in the facility.</p> <p>On 3/26/19 at 12:07 PM and 4:20 PM, Resident #38 was near the dining room talking with a therapy staff member, and in her room,</p> | F 583 | <p>chose to keep their arm bracelet on, and their desire was noted in the resident's care plan and Kardex. This was completed on 3/27/2019.</p> <p>2. All residents were checked for arm bracelets on 3/27/2019. All future residents admitted from a hospital wearing an arm bracelet with personal information will have the bracelet removed upon admission unless resident states they want it left on.</p> <p>3. The DNS will educate nursing staff by 4/30/2019 regarding the importance of providing personal privacy for all residents. Staff will be informed of the specific health concerns through the care plan and Kardex. The arm bracelets will be removed during the admission process by nursing unless the resident states they want it left on.</p> <p>4. The DNS or designee will audit compliance by checking all residents to assure none are wearing arm bracelets from a hospital with personal information unless resident states they want it left on. 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> <p>5. The facility will be in compliance on or before 04/30/2019. The Administrator or designee will ensure compliance.</p> | | |

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| F 583 | <p>Continued From page 10 respectively, and had both bracelets visible.</p> <p>On 3/27/19 at 12:53 PM, Resident #38 was in the dining room and had both bracelets visible. Since her admission, Resident #38 had the arm bracelets on for 29 days.</p> <p>On 3/27/19 at 2:43 PM, LPN #1 said Resident #38's "Restricted Extremity" bracelet was left on to remind staff to not take blood pressures in her left arm due to her dialysis access port.</p> <p>On 3/27/19 at 3:19 PM, the DON said she expected staff to leave Resident #38's "Restricted Extremity" bracelet on due to her dialysis access port and to remove her "Fall Risk" bracelet.</p> <p>c. Resident #142 was admitted to the facility on 3/8/19, with multiple diagnoses including left femur fracture (leg).</p> <p>On 3/25/19 at 1:40 PM, Resident #142 was on her bed in her room and had a yellow bracelet which documented "FALL RISK" on her right wrist. Resident #142 said she had it on since she had been in the facility and was not sure why she had it on.</p> <p>On 3/26/19 at 10:19 AM, Resident #142 was on her bed in her room with the yellow bracelet on.</p> <p>On 3/26/19 at 4:14 PM, Resident #142 was in the hallway near the nurses' station with several residents in the hallway. LPN #1 assisted Resident #142 take her coat off, which exposed the yellow bracelet.</p> | F 583 | | |

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| F 583 | <p>Continued From page 11</p> <p>On 3/27/19 at 10:06 AM and 12:55 PM, Resident #142 was in her room and in the dining room, respectively, and had the bracelet visible. Since her admission, Resident #142 had the arm bracelet on for 19 days.</p> <p>d. Resident #92 was admitted to the facility on 3/7/19, with multiple diagnoses including respiratory failure and cognitive impairment.</p> <p>On 3/25/19 at 2:30 PM, Resident #92 had a yellow bracelet on his wrist which documented "FALL RISK." Resident #92 said he did not know why he had the bracelet. Since his admission, Resident #92 had the arm bracelet on for 18 days.</p> <p>e. Resident #10 was readmitted to the facility on 3/22/19, with multiple diagnoses including cognitive impairment.</p> <p>On 3/25/19 at 3:00 PM, Resident #10 was observed with a bracelet on his wrist which documented "FALL RISK." At that time, Resident #10 said the bracelet was there "to make you wonder." Since his admission, Resident #10 had the arm bracelet on for 3 days.</p> <p>On 3/27/19 at 2:11 PM, CNA #2 said she thought the bracelets were placed on the residents by the local hospital.</p> <p>On 3/27/19 at 2:15 PM, CNA #3 said the bracelets were placed on the residents by the local hospital and the facility nurses were responsible to take them off. CNA #3 said if residents were a fall risk that would be communicated to staff verbally, in the care plan,</p> | F 583 | | | |

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| F 583 | Continued From page 12 and when fall precautions like fall mats were implemented. On 3/27/19 at 2:19 PM, RN #2 said the bracelets were placed on the residents by the local hospital and nurses in the facility left them on for about a week. On 3/27/19 at 2:43 PM, LPN #1 said residents came from the hospital with the bracelets on and there was no set time for when facility staff would cut them off. On 3/27/19 at 3:19 PM, the DON said she expected nursing staff to remove the "FALL RISK" and "DNR" bracelets during the admissions process because personal and medical information could be disclosed to others. | F 583 | | | |
| 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. (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 (iii) Include in the notice the items described in paragraph (c)(5) of this section. | F 623 | | 4/30/19 | |

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| F 623 | <p>Continued From page 13</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, 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</p> | F 623 | | | |

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

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FORM APPROVED
OMB NO. 0938-0391

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| F 623 | <p>Continued From page 14</p> <p>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 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:</p> | F 623 | | | |

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| F 623 | <p>Continued From page 15</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure transfer notices were provided in writing to the Ombudsman. This was true for 2 of 3 residents (#14 and #39) reviewed for transfers. This created the potential for residents to be inappropriately discharged without access to an advocate who could inform them of their options and rights. Findings include:</p> <p>The facility's Discharges and Transfers policy, dated 9/2017, documented when a facility-initiated transfer or discharge occurred the facility must notify the Office of the State Long-Term Care Ombudsman.</p> <p>a. Resident #14 was admitted to the facility on 12/29/16, with multiple diagnoses including hypertension (high blood pressure).</p> <p>Resident #14's Nurse's Progress Notes, documented she was transferred to the hospital for evaluation on 10/3/18 and was readmitted to the facility on 10/9/18, with a diagnosis of pneumonia. Resident #14's record did not include documentation the facility sent a written notice her transfer to the Ombudsman.</p> <p>b. Resident #39 was admitted to the facility on 6/13/14, with multiple diagnoses including chronic pain.</p> <p>Resident #39's record documented she was hospitalized from 2/16/19 to 2/19/19 with influenza (flu) complications. Resident #39's record did not document the facility sent a written notice to the Ombudsman of the transfer to the hospital.</p> | F 623 | <p>F- 623 Notice Requirements Before Transfer/Discharge</p> <p>1. It was determined the facility failed to ensure transfer notices were provided in writing to the Ombudsman. Notification of the transfers of residents #14 and 39 were sent to the Ombudsman on 4/15/2019.</p> <p>2. The HIM Director and DSS will audit records of all residents who were discharged or transferred from March 1st, 2019, going forward to ensure that proper notification was provided to the Ombudsman. The first monthly notification, of transfers occurring in March, 2019, will be sent at the beginning of April 2019.</p> <p>3. The facility DSS will make notifications to the Ombudsman using the method and guidelines provided in the March 13, 2019 letter from Cathy Hart, Idaho State Long-Term Care Ombudsman, which details "New instructions for submission." The administrator or designee will provide education to nursing staff and social service staff on or before 4/30/2019 regarding Discharge and Transfer notices to the Ombudsman.</p> <p>4. The administrator or designee will audit all medical records of residents who discharged or transferred to assure proper notification was made to the Ombudsman. This audit will be done monthly X4 with the administrator or designee reporting the audit findings to the QAPI committee. The committee will determine if further auditing is needed.</p> | | |

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| F 623 | Continued From page 16 On 3/28/19 at 9:40 AM, the Medical Records Director said the facility had not been submitting hospital transfer information to the Ombudsman. On 3/28/19 at 3:10 PM, the Administrator said the facility had not been submitting hospital transfer information to the Ombudsman. | F 623 | 5. The facility will be in compliance on or before 04/30/2019. The Administrator or designee will ensure compliance. | | |
| F 625 SS=D | Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy | F 625 | | 4/30/19 | |

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| F 625 | <p>Continued From page 17 described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to provide the required bed hold notice to residents or their responsible party when residents were transferred to the hospital. This was true for 3 of 3 (#10, #14, and #39) residents reviewed for resident transfers. This deficient practice created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time and may cause psychosocial distress if not informed they may be charged to reserve their bed/room. Findings include:</p> <p>The facility's Bed Hold policy, dated 9/2017, directed staff to give a bed hold notice at the time the resident was transferred to the hospital.</p> <p>a. Resident #39 was admitted to the facility on 6/13/14, with multiple diagnoses including chronic pain.</p> <p>Resident #39's record documented she was transferred to the hospital on 2/16/19 for influenza complications and was readmitted to the facility on 2/19/19. Resident #39's record did not document the facility provided her or her representative with a written bed hold notice.</p> <p>b. Resident #14 was admitted to the facility on 12/29/16, with multiple diagnoses including hypertension.</p> <p>Resident #14's Nurse's Progress Notes, documented she was transferred to the hospital</p> | F 625 | <p>F- 625 Notice of Bed Hold Policy Before/Upon Transfer</p> <p>1. It was determined that the facility failed to provide the required bed hold notice to residents or their responsible party when residents were transferred to the hospital. Residents # 10, 14, and 39 were transferred to the hospital without a bed hold notice given to them. The facility is unable to provide notice to those specific residents at this late date.</p> <p>2. The facility HIM director and DSS audited all resident records and saw that no facility initiated transfers occurred between the end of the state survey to April 11, 2019 – which is the date that the facility received the Statement of Deficiencies letter.</p> <p>3. The administrator or designee will provide education to the nurses and social service staff regarding the center's bed hold policy and procedures in order to remain in compliance with regulations. It will be the facility practice that a bed hold notice must be provided to the resident, and if applicable the resident's representative, at the time of transfer, or in cases of emergency transfer, within 24 hours. It will be the facility social worker's responsibility to provide notification to the resident. However, the charge nurse will be responsible for completion of notification procedures if the transfer occurs at a time the social worker is not at the location.</p> | | |

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| F 625 | Continued From page 18 on 10/3/18 for evaluation and was readmitted to the facility on 10/9/18, with a diagnosis of pneumonia. Resident #14's record did not document the facility provided her or her representative with a written bed hold notice. c. Resident #10 was readmitted to the facility on 3/22/19, with multiple diagnoses including cognitive impairment. Resident #10's record documented he was transferred to the hospital on 3/21/19 for inadequate oxygen in the blood. Resident #39's record did not document the facility provided him or his representative with a written bed hold notice. On 3/28/19 at 9:40 AM, the Medical Records Director said the facility had not been providing bed hold notices because the facility always held the residents' bed while they were in the hospital. On 3/28/19 at 3:10 PM, the Administrator said the facility had not been providing bed hold notices. | F 625 | 4. The administrator or designee will audit all residents who have had a facility initiated transfer. The audit will check if a notice was provided to the resident and/or resident representative. This audit will be done monthly X4 with the administrator or designee reporting the audit findings to the QAPI committee, the committee will determine if further auditing is needed. 5. The facility will be in compliance on or before 04/30/2019. The Administrator or designee will ensure compliance. | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - | F 656 | | 4/30/19 | |

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| F 656 | <p>Continued From page 19</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, resident and staff interview, it was determined the facility failed to develop and implement comprehensive resident-centered care plans that included a resident's code status. This was true for 1 of 12 residents (#142) whose care plans were reviewed. These failures increased the residents'</p> | F 656 | <p>F- 656 Develop/Implement Comprehensive Care Plan</p> <p>1. It was determined that the facility failed to develop and implement comprehensive resident-centered care plans that included a resident's code status. To correct this error, the facility</p> | | |

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| F 656 | Continued From page 20 risk of not having their decisions honored and respected when unable to make or communicate health care preferences. Findings include: The facility's Comprehensive Care Plan policy, dated 10/2018, documented the care plan should be developed and include services to attain or maintain residents' highest practicable physical, mental, and psychological well-being, and the right to exercise rights, including the right to refuse treatment. Resident #142 was admitted to the facility on 3/8/19, with multiple diagnoses including hypertension. Resident #142's care plan did not include documentation of her code status. On 3/27/19 at 10:05 AM, Resident #142 said her code status was to be DNR. On 3/28/19 at 2:43 PM, the Administrator said Resident #142's code status was not found on the care plan and he expected it to be on the care plan. | F 656 | updated resident #142s care plan to include their desired code status. 2. The facility HIM director and MDS coordinator will audit all current resident care plans to ensure that their code status is documented. 3. The administrator or designee will provide education to the nursing and social service staff regarding the requirement of having resident code status added to care plans – to be checked at each care plan meeting. 4. The administrator or designee will audit all care plans to ensure a current code status is documented on the care plan. If a code status is changed this will be reflected on the care plan. This audit will be completed monthly X4. The administrator or designee will report the audit findings to the QAPI committee monthly and the committee will determine if further auditing is needed. 5. The facility will be in compliance on or before 04/30/2019. The Administrator or designee will ensure compliance. | | |
| F 684 SS=D | Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. | F 684 | | 4/30/19 | |

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| F 684 | <p>Continued From page 21</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interview, it was determined the facility failed to ensure residents received necessary medication in a timely manner. This was true for 1 of 12 residents (Resident #96) whose records were reviewed for medication management. The failure created the potential for harm if Resident #96 experienced seizures when her anti-seizure medication was not provided for 2 days. Findings include:</p> <p>Resident #96 was admitted to the facility on 3/20/19, with multiple diagnoses including seizures.</p> <p>Resident #96's March 2019 MAR, documented a physician's order, dated 3/20/19, for Phenobarbital each night for seizures. The MAR documented she did not receive the medication as ordered on 3/20/19 and 3/21/19. The record did not document the physician was notified of the missed doses.</p> <p>On 3/25/19 at 1:30 PM, Resident #96 said she did not receive her seizure medication on the day of her admission and the day after that.</p> <p>On 3/27/19 at 11:00 AM, the Medical Director said he expected to be notified if the facility was unable to follow physician's orders for resident care, including if a medication was not administered as ordered.</p> <p>On 3/28/19 at 12:33 PM, the DON said Resident #96 did not receive her Phenobarbital as ordered on 3/20/19 and 3/21/19 because the medication</p> | F 684 | <p>F- 684 Quality of Care</p> <ol style="list-style-type: none"> 1. It was determined that the facility failed to ensure residents received necessary medication in a timely manner. Resident #96 had physician notification of the missed medication on 3/22/2019. 2. All resident incidents of missed medication or other medication irregularity will have physician notification as soon as possible to correct the error and make appropriate changes per the provider, and document in progress notes. 3. The DNS or designee will provide education to the licensed nursing staff by 4/30/19 regarding medication errors. The facility P/P "Medication Errors" will be reviewed with copies available to the staff. All medication errors will have an incident report filed, the physician, family, DNS, and administrator will be notified, new orders obtained and processed. The DNS will track all medication errors per nurse to monitor safe medication handling. 4. The DNS or designee will audit documentation of medication passes to ensure the correct process is being used weekly X4 and then monthly X3. The audit will include a review of incident reports to assure the provider and family were notified timely and that proper follow-up was complete. A review of medication errors and follow-up education or corrective action will be included in this audit. The DNS will report audit findings to the QAPI committee monthly and the | | |

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| F 684 | Continued From page 22 was not available in the facility until 3/22/19. | F 684 | committee will determine if further action is needed. 5. The facility will be in compliance on or before 04/30/2019. The Administrator or designee will ensure compliance. | | |
| 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 record review, review of the facility/dialysis provider agreement, and resident and staff interview, it was determined the facility failed to ensure that pre and post-dialysis assessments were completed and there was adequate communication between the facility and a dialysis provider for 1 of 1 resident (Resident #38) who was reviewed for dialysis. This failure created the potential for harm if undetected complications went untreated or if there was a delay in treatment. Findings include: The facility/dialysis provider agreement, made and entered into on 10/22/10, documented the facility and dialysis provider were to communicate and document in writing in a timely manner all dialysis-related information pertinent to a resident's skilled nursing plan of care. The agreement documented residents were to receive follow-up care, observation, and monitoring. | F 698 | F- 698 Dialysis 1. It was determined the facility failed to ensure that pre and post-dialysis assessments were completed and there was adequate communication between the facility and dialysis provider for 1 of 1 resident who was reviewed for dialysis. Resident # 38 is now having Clinical monitoring for dialysis documented on facility form # 862 "Dialysis Communication/Referral" with the first section labeled "license nurse to complete following section" done prior to going to dialysis. The dialysis center has been informed that they are responsible to complete the second section labeled "dialysis to complete following section "and return this to the center; HIM will scan this into Resident Spaces after it has been reviewed by the nurse. 2. All residents receiving dialysis will have the Clinical Monitoring | 4/30/19 | |

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| F 698 | <p>Continued From page 23</p> <p>The facility dialysis communication form, dated 9/2009, had three sections with instructions for facility staff to complete pre-dialysis assessments. The dialysis center was to complete the second section with a pre-dialysis and post-dialysis assessments. The pre and post-dialysis sections included areas to document vital signs (temperature, blood pressure, pulse, and respirations), weights, the condition of the access/site, and whether thrill and bruit were present. The vibration of blood going through a person's arm is called the "thrill." This should be checked several times a day. If the "thrill" changes or stops a blood clot may have formed. By using a stethoscope, or even putting an ear to the access site, the sound of blood flowing through the access can be heard. This sound is called the "bruit." If the sound gains in pitch and sounds like a whistle, the blood vessels could be tightening (called stenosis). If the tightening becomes too severe, blood flow could be cut off completely. The dialysis communication form also included space for the signature/title of the person completing each section.</p> <p>Resident #38 was admitted to the facility on 2/26/19, with multiple diagnoses including kidney failure.</p> <p>Resident #38's admission physician orders, dated 2/26/19, documented she received dialysis and to apply Iodocaine cream to her left arm fistula (access port for dialysis treatment) 30 minutes to 1 hour prior to dialysis every Monday, Wednesday, and Friday.</p> <p>Resident #38's care plan directed staff to monitor</p> | F 698 | <p>documentation on form # 862 with first section labeled "license nurse to complete following section "done prior to going to dialysis and the dialysis center will complete second section labeled "Dialysis to complete following section" and return the document to the nursing home with the resident. Nursing staff in the center will review this document and make any necessary changes for the resident and then give to HIM to scan into Resident Spaces.</p> <p>3. The DNS will provide education to all nurses and HIM staff on conducting pre and post-dialysis assessments as well as communication between the facility and dialysis provider using facility form #862 "Dialysis Communication/Referral." This education will be completed by 4/30/19.</p> <p>4. The HIM or designee will audit the medical record of all residents receiving renal dialysis to assure that the Clinical monitoring on form # 862 has been completed prior to dialysis and received after the resident has returned from the dialysis center. The audit will include a nurse's signature to verify it has been reviewed and then scanned into Resident Spaces. This audit will be done weekly X4 and then monthly X3 with the HIM or designee reporting the audit findings to the QAPI committee, the committee will determine if further auditing is needed.</p> <p>5. The facility will be in compliance on or before 04/30/2019. The Administrator or designee will ensure compliance.</p> | | |

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| F 698 | <p>Continued From page 24 and document signs and symptoms of renal insufficiency, changes in heart sounds, and to monitor the access site.</p> <p>On 3/25/19 at 4:20 PM, Resident #38 said she went to dialysis on Monday, Wednesday, and Friday and said staff checked her vital signs and fistula site before and after dialysis. She said facility staff did not check for thrill and bruit on days she went to dialysis.</p> <p>There were no pre/post dialysis communication records for Resident #38 in her record.</p> <p>On 3/27/19 at 2:19 PM, RN #2 said on the days Resident #38 went to dialysis, she checked her vital signs and sent dialysis communication paperwork with Resident #38 to the dialysis center. RN #2 said when Resident #38 came back from dialysis she would give nurses a verbal report on how her treatment went. RN #2 said she would check her access site and vital signs. RN #2 said she only checked Resident #38's thrill and bruit on days she did not go to the dialysis provider.</p> <p>On 3/27/19 at 2:43 PM, LPN #1 said she checked Resident #38's vital signs before and after she went to dialysis and completed the dialysis communication form. LPN #1 said the medical records department was responsible for scanning those communication forms into residents' records.</p> <p>On 3/27/19 at 3:05 PM and on 3/28/19 at 9:15 AM, the Medical Records Director said there had been no dialysis communication forms for Resident #38 since she was admitted. She said</p> | F 698 | | | |

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

PRINTED: 04/25/2019
FORM APPROVED
OMB NO. 0938-0391

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| F 698 | <p>Continued From page 25</p> <p>she had checked with Resident #38's dialysis provider and said they did not have a record of her dialysis communication forms.</p> <p>On 3/28/19 at 10:01 AM, the DON said she expected staff to complete dialysis communication forms and expected staff to check Resident #38's thrill and bruit due the importance of blood flow concerns.</p> <p>The facility failed to communicate with Resident #38's dialysis provider and adequately assess her prior to and after dialysis treatments.</p> | F 698 | | | |



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN – Director

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June 24, 2019

Craig Perez, Administrator
Good Samaritan Society - Idaho Falls Village
840 East Elva Street
Idaho Falls, ID 83401-2899

Provider #: 135092

Dear Mr. Perez:

On **March 25, 2019** through **March 29, 2019**, an unannounced on-site complaint survey was conducted at Good Samaritan Society - Idaho Falls Village. The complaint allegations, findings and conclusions are as follows:

Complaint ID00007940

ALLEGATION #1:

The facility failed to ensure residents were provided palatable menu items.

FINDINGS #1:

During the survey, observations were conducted, a meal tray was tasted by surveyors, and residents, family and staff were interviewed.

Observations were conducted throughout the facility, during meal and snack times. Planned meals were reviewed and approved by the registered dietitian. Sandwiches with a condiment of choice was provided for residents with planned snacks. Sandwiches were also available to residents without planned snacks and a condiment of choice was provided.

Craig Perez, Administrator
June 24, 2019
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A test tray was requested and sampled by the surveyors and dietary manager. The food was found to be palatable and appropriately seasoned without excess salt.

Interviews were conducted with four residents, three family members and three staff members including the cook, dietary manager, and the registered dietitian. Concerns with menu items were not expressed.

It could not be determined the facility failed to ensure residents were provided palatable menu items. Therefore, the allegation could not be substantiated and no deficiencies were cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility failed to ensure residents were provided with eyeglasses when needed and that their personal property was treated with respect and not misused by others.

FINDINGS #2:

Observations were conducted throughout the facility and interviews were conducted with twelve residents, three families and five staff.

Residents with eyeglasses wore them as they chose and there were no reports of residents needing to have eyeglasses repaired or replaced. There were also no reports of damaged or missing personal property that was not replaced during the interviews.

An interview with the Administrator was conducted on 3/27/19 at 5:00 PM. The Administrator stated missing/stolen or damaged items were reported to the Administrator and investigated. The Administrator stated items were repaired/replaced as needed.

The facility's records did not include reports of missing resident funds and/or evidence of funds not returned to residents when appropriate and there were no grievances or incidents/accidents on file which documented missing or damaged items.

It could not be determined that the facility failed to ensure residents were provided with eyeglasses when needed or that their personal property was not treated with respect and not misused by others. Therefore, the allegation could not be substantiated and no deficiencies were cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility failed to ensure call bells were answered in a timely manner and residents are provided with appropriate assistance when using the bathroom.

FINDINGS #3:

During the survey observations were conducted, interviews with residents, families and staff were conducted and facility grievance records were reviewed.

The facility monitored its call bell system and reported the call bells were answered within 4 minutes. The facility's grievances did not include reports of prolonged response to call bells and during the resident group meeting there were no complaints of residents waiting for prolonged periods when using the call bell system.

Observations of staff response to call bells were made each day of the survey. Call bells were responded to by staff in a prompt manner. Observations of care being provided were also conducted for four residents. The observations demonstrated care was provided according to the residents' plans of care, which included staying with the resident while they were on the toilet when needed.

It could not be determined that the facility failed to ensure call bells were answered in a timely manner or that residents were provided with appropriate assistance when using the bathroom. Therefore, the allegation could not be substantiated and no deficiencies were cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility failed to ensure effective pest control measures were taken.

Craig Perez, Administrator
June 24, 2019
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FINDINGS #4:

During the survey staff were interviewed, observations were conducted, and residents and family members were interviewed.

An interview with the Administrator was conducted on 3/27/19 at 5:00 PM. The Administrator stated the facility had a bedbug infestation last summer, but currently had an effective pest management plan in place.

Observation of resident rooms, common areas and service areas were conducted and no insects were present. Interviews were conducted with eight residents during a group meeting and three families were interviewed with no reports of pests. Staff interviews were also conducted and there were no reports of insects in the facility.

It could not be determined the facility failed to ensure effective pest control measures were taken. Therefore, the allegation could not be substantiated, and no deficiencies were cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj