



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
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

September 16, 2019

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

Provider #: 135067

Dear Ms. Berg:

On **August 30, 2019**, 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 an isolated 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 **September 26, 2019**. Failure to submit an acceptable PoC by **September 26, 2019**, may result in the imposition of penalties by **October 19, 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 **October 4, 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 **November 28, 2019**. A change in the seriousness of the deficiencies on **October 14, 2019**, may result in a change in the remedy.

Jamie Berg, Administrator
September 16, 2019
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **November 28, 2019** includes the following:

Denial of payment for new admissions effective **November 28, 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 **February 26, 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 Chief, 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 **November 28, 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:

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

Jamie Berg, Administrator
September 16, 2019
Page 4 of 4

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

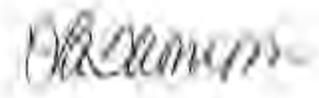
- BFS Letters (06/30/11)

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

This request must be received by **September 26, 2019**. If your request for informal dispute resolution is received after **September 26, 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,



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj

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

PRINTED: 09/26/2019
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 C 08/30/2019
--	---	--	---

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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during a complaint survey conducted at the facility from August 28, 2019 to August 30, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Jim Troutfetter, QIDP, Team Coordinator Karen George, RN</p> <p>Common abbreviations used in this report are:</p> <p>MAR - Medication Administration Record RN - Registered Nurse TAR - Treatment Administration Record</p>	F 000		
F 657 SS=D	<p>Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)</p> <p>§483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p>	F 657		10/4/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 09/23/2019
---	-------	--------------------------------

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.

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 C 08/30/2019
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 657	<p>Continued From page 1</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident and staff interview, policy review, and record review, it was determined the facility failed to ensure residents' care plans were regularly reviewed and revised as needed. This was true for 2 of 6 residents (#1 and #2) reviewed for care plan revisions and created the potential for harm if care was not provided to meet residents' needs. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 8/17/17 with diagnoses that included dementia. She was transferred to the hospital on 7/2/19 and did not return to the facility.</p> <p>Resident #1's oral care data, dated 1/2019 - 6/2019, was reviewed and documented she had refused oral care as follows:</p> <p>* 1/2019: 1 refusal * 2/2019: 0 refusals * 3/2019: 10 refusals * 4/2019: 15 refusals * 5/2019: 17 refusals * 6/2019: 17 refusals</p> <p>There was no documentation Resident #1's care plan was updated to include goals and interventions related to her increased refusals of oral care.</p>	F 657	<p>Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations manual.</p> <p>1.a. N/A - Resident #1 no longer resides in the facility. b. Resident #2's care plan was updated to address skin issues.</p> <p>2. All residents' care plans will be reviewed and revised, if necessary, to ensure current skin issues and refusals of care are being reflected.</p> <p>3. The QAPI Team determined the root</p>		

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 C 08/30/2019
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 657	<p>Continued From page 2</p> <p>On 8/29/19 at 4:04 PM, the Social Worker stated Resident #1's care plan did not address her refusal of oral care.</p> <p>The facility failed to ensure Resident #1's care plan was updated to reflect the increased refusals of oral care.</p> <p>2. Resident #2 was admitted to the facility on 7/17/18 with diagnoses including a history of candidiasis (a fungal infection caused by yeast).</p> <p>On 8/28/19 at 10:14 AM, Resident #2 said she had yeast under her breasts and in her groin area and it was an ongoing problem.</p> <p>Resident #2's Medication Review Report, dated 8/22/19, documented a physician's phone order written for InterDry (a moisture-wicking antimicrobial fabric) to apply under her breasts, in the abdominal fold, and in the groin area for redness and moisture. The order start date was 2/7/19. A second order was to apply Nystatin cream (an antifungal topical medication) 100000 Units/gm [grams] to the underside of the breasts topically as needed for yeast infection. The order start date was 12/10/18.</p> <p>Resident #2's TAR, from 2/1/19 through 8/29/19, documented Resident #2 required Nystatin treatment for the rash under her breasts throughout that time period.</p> <p>Resident #2's Skin Observation sheets, dated 8/1/19 through 8/22/19, documented the following:</p>	F 657	<p>cause of the deficiency was the lack of the Care Team updating care plans timely. A weekly meeting for care plan review will be implemented to ensure all resident care plans are current. The care team will be educated on the new meeting.</p> <p>4. The Social Services Director, Care Manager or designee will audit the care plans for all new admissions weekly X 4 and monthly X 2. All findings will be reported to the QAPI Committee for further monitoring and modification.</p>		

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

PRINTED: 09/26/2019
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 C 08/30/2019
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 657	<p>Continued From page 3</p> <p>*8/1/19 Skin Check: Description - Redness in bilateral groin area Treatment - Nystatin cream</p> <p>*8/8/19 Skin Check: Description - Redness and soreness under both breasts and left and right pannus (dense layer of fatty tissue in the lower abdominal region) Treatment - Nystatin cream</p> <p>* 8/15/19 Skin Check : Description - Healing scratch to [right] buttock Treatment - None</p> <p>* 8/22/18 Skin Check: Description - Pannus redness, left breast redness, maceration (occurs when skin is in contact with moisture for too long and looks lighter in color and is wrinkly), and tenderness Treatments - topical Nystatin cream</p> <p>The facility's Pressure Ulcer Practice Guidelines, revised 9/2016, provided by the Administrator as the policy the facility utilized to guide skin care, documented an initial skin assessment was performed by the nurse on new admissions and readmissions. Identified areas of risk were identified and interventions care planned.</p> <p>Resident #2's care plan did not include a plan to address her ongoing candidiasis skin issues.</p> <p>On 10/29/19 at 10:20 AM, the Minimum Data Set Nurse Manager said Resident #2's skin issue was not on the care plan because she had not gotten to it yet.</p>	F 657			

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 C 08/30/2019
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 657	Continued From page 4	F 657			
F 684 SS=D	<p>On 8/30/19 at 8:43 AM, the Administrator said if someone had an ongoing problem like a yeast infection, they expected the issue to be on the care plan.</p> <p>The facility failed to ensure Resident #2's care plan was updated to address her skin issues.</p> <p>Quality of Care CFR(s): 483.25</p> <p>§ 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. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure physician orders were followed when providing skin care for 1 of 6 residents (Resident #2) whose physician's orders were reviewed. This created the potential for Resident #2's skin condition to worsen. Findings include:</p> <p>Resident #2 was admitted to the facility on 7/17/18 with multiple diagnoses including candidiasis (a fungal infection caused by yeast).</p> <p>Resident #2's Medication Review Report, dated 8/22/19, documented a physician's phone order written for InterDry (a moisture-wicking</p>	F 684	<p>Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations manual.</p>	10/4/19	

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 C 08/30/2019
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 684	<p>Continued From page 5</p> <p>antimicrobial fabric) to apply under her breasts, in the abdominal fold, and in the groin area for redness and moisture. The order start date was 2/7/19. A second order was to apply Nystatin cream (an antifungal topical medication) 100000 Units/gm [grams] to the underside of the breasts topically as needed for yeast infection. The order start date was 12/10/18.</p> <p>Resident #2's TAR, from 2/1/19 through 8/29/19, included the order for the Nystatin treatment for the rash under Resident #2's breasts continued on the TAR throughout the time period. Weekly Skin Observation sheets, from 8/1/19 through 8/22/19, documented the following:</p> <p>* 8/1/19 Skin Check: Description - Redness in bilateral groin area Treatment - Nystatin cream</p> <p>* 8/8/19 Skin Check: Description - Redness and soreness under both breasts and left and right pannus (dense layer of fatty tissue in the lower abdominal region) Treatment - Nystatin cream</p> <p>* 8/15/19 Skin Check: Description - Healing scratch to [right] buttock Treatment - None</p> <p>* 8/22/18 Skin Check: Description - Pannus redness, left breast redness, maceration (occurs when skin is in contact with moisture for too long and looks lighter in color and is wrinkly), and tenderness Treatments - topical Nystatin cream</p>	F 684	<ol style="list-style-type: none"> 1. Resident #2's MAR/TAR was updated to include InterDry. 2. All residents' medication and treatment orders will be reviewed to ensure they were carried over to the MAR/TAR for documentation. 3. The QAPI Team determined the root cause of the deficiency was a nurse not processing an order correctly in PCC. A system change will be implemented regarding processing physicians' orders. All nurses and HIM will be educated on the new system change and will also be re-educated on the steps of how to process a physician's order in PCC. 4. The DNS or designee will audit new physician orders and MARs/TARs weekly X 4 and monthly X 1. All findings will be reported to the QAPI Committee for further monitoring and modification. 		

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 C 08/30/2019
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 684	<p>Continued From page 6</p> <p>On 8/28/19 at 10:14 AM, Resident #2 said she had yeast under her breasts and in her groin area. She said she believed she was to have cream applied to these areas two times a day and said it rarely happened. Resident #2 said staff usually applied the cream after her bath, which was two days a week, but other than after her bath, the nurse rarely applied the cream. She said she currently had a rash.</p> <p>On 8/28/19 at 1:35 PM, Resident #2 said the staff had not applied the cream so far that day.</p> <p>On 8/29/19 at 8:26 AM, Resident #2 said no one applied the cream to her rash yesterday and the cream had not been applied yet that morning. She expected the staff would apply the cream later when she had her bath, but she did not know for sure what time that would be.</p> <p>During an observation and interview, on 8/29/19 at 10:25 AM, a dark red rash was observed under Resident #2's left breast and under her pannus on the left side. The skin of the right groin area was pink in color. Resident #2 said the rash did not hurt it but it was "itchy."</p> <p>On 8/29/19 at 10:13 AM, RN #1 presented the InterDry product and said the facility had not used InterDry on Resident #2 often because the Nystatin cream seemed to do "pretty good for her." RN #1 did not think there was documentation for the use of InterDry in Resident #2's record. He said the InterDry was not on Resident #2's TAR. There was no evidence InterDry was used on Resident #2. There was no documentation the facility followed the</p>	F 684			

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

PRINTED: 09/26/2019
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 C 08/30/2019
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 684	Continued From page 7 physician's order. On 8/29/19 at 10:20 AM, the Director of Nursing Services, after checking the InterDry order, said the order for the InterDry was not on Resident #2's MAR. On 8/29/19 at 10:20 AM, the Minimum Data Set Nurse Manager said she did not know why the order for InterDry was not on Resident #2's TAR.	F 684			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
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

September 30, 2019

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

Provider #: 135067

Dear Ms. Berg:

On **August 28, 2019** through **August 30, 2019**, an unannounced on-site complaint survey was conducted at Good Samaritan Society - Moscow Village. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008181

ALLEGATION #1:

The facility failed to ensure residents' care plans were regularly reviewed and revised as needed to prevent deterioration of the residents' overall health.

FINDINGS #1:

Record reviews, observations, and interviews were conducted with the following results:

Six residents' records were reviewed. One resident's oral care data documented she began refusing oral care in March of 2019. The resident had an average of 15 refusals per month from March 2019 through June 2019. However, no documentation could be found that her care plan had been updated to reflect her increase in refusals of oral care.

Additionally, the resident's record contained a Progress Note, dated 7/2/19, which documented she was discovered to have a sore mouth with pus present during the morning of 7/2/19. The Progress Note documented the physician was immediately notified and she was then admitted to a local hospital for treatment.

During an interview on 8/29/19 at 4:04 PM, the Social Worker stated there was no care plan for refusal of oral care.

A second resident's record contained a physician order for a medication which was to start on 12/10/18, for a skin issue. The resident's record contained a physician order for a second medication for her skin issue which was to start on 2/7/19. However, the prescribed 12/10/18 medication was not given as needed to resolve the skin issue. Further, her Treatment Administration Record documented she was not administered the prescribed 2/7/19 medication as of 8/29/2019.

The second resident was interviewed on 8/28/19 at 10:14 AM, and stated she had "yeast" under her breasts and in her groin area. She said she believed she was supposed to have cream applied to these areas two times a day and stated, "This rarely happens." The resident stated staff usually apply the cream after her baths, which was two days a week, but other than that the nurse rarely applied the cream. She said she currently had a rash.

The second resident was interviewed again, on 8/29/19 at 8:26 AM, and stated no one had come in yesterday or today to apply cream to her rash. The surveyor asked to perform a skin integrity check and it was noted that the resident's skin issue had not been resolved.

However, no documentation could be found that her care plan had been updated to reflect her ongoing skin issues. Further, the last update to her care plan was February 2019.

During an interview on 08/29/19 at 10:20 AM, the Director of Nursing Services stated after checking the order for the 2/7/19 medication, "who ever put the order into the system did not check PRN (as needed) and so the order did not get triggered into the MAR (medication administration record)."

During an interview on 8/29/19 at 10:20 AM, the Minimum Data Set Nurse Manager stated she did not know why the order for the 2/7/19 medication had not shown up on the Treatment Administration Record and said the skin care issue probably had not shown up on the care plan because she hadn't gotten to it yet.

During an interview on 8/30/19 at 8:43 AM, the Administrator stated if someone had an ongoing problem like a yeast infection, they normally expect it to show up on the care plan.

It was determined the facility failed to ensure residents' care plans were regularly reviewed and revised as needed to prevent deterioration of the residents' overall health. Therefore, the allegation was substantiated, and deficient practice was cited at F657 and F684.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The facility failed to ensure residents received appropriate grooming services, to include adequate oral care.

FINDINGS #2:

During the survey resident record reviews and interviews were conducted with the following results:

Six residents' records were reviewed. One resident's oral care data documented she began refusing oral care in March of 2019. The resident had an average of 15 refusal per month from March 2019 through June 2019. However, no documentation could be found that her care plan had been updated to reflect her increase in refusals of oral care.

During an interview on 8/29/19 at 4:04 PM, the Social Worker stated there was no care plan for refusal of oral care.

Additionally, the residents record contained a Progress Note, dated 7/2/19, which documented she was discovered to have a sore mouth with puss present during the morning of 7/2/19 and that the resident was also noted to have deep vein thrombosis (DVT). The Progress Note documented the physician had been immediately notified of both conditions. She was then admitted to a local hospital for treatment for a primary medical issue and the oral care issue as the secondary concern.

A discharge summary from the local hospital, dated 7/5/19, documented she had oral mucositis a medical term that is used to refer to mouth sores which can range in severity from a red, sore mouth and/or gums to open sores that can cause a patient to be unable to eat. The oral mucositis section of the summary documented the "Patient has significant concerning oral findings for poor oral intake and dehydration...Could also be possible fungal infection..."

Therefore, the allegation was substantiated and deficient practice was cited at F657.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

Facility failed to ensure appropriate dental services were provided to residents when there was an indication such services were needed by the resident.

FINDINGS #3:

During the survey interviews and record reviews were conducted with the following results:

Six residents records were reviewed. One resident's record contained a Progress Note, dated 7/2/19. The progress note documented the resident was discovered to have a sore mouth with pus present during the morning of 7/2/19 and that the resident was also noted to have deep vein thrombosis (DVT). The progress note also documented that the pus had not been present the previous night and that the physician had been immediately notified of both conditions. The resident was then admitted to a local hospital for treatment.

Because the resident's oral condition was reported immediately to the physician and the resident had been subsequently discharged to the hospital, it could not be determined that appropriate dental care had not been provided.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility failed to ensure residents were appropriately assessed and monitored to prevent degeneration of skin surfaces and development of vascular issues.

FINDINGS #4:

During the survey record reviews, observations, and interviews were conducted with the following results:

Jamie Berg, Administrator
September 30, 2019
Page 5 of 5

Six residents' records were reviewed. One resident's record documented she had a yeast infection under her breasts and in her groin area. However, no skin care plan related to her on-going yeast infection could be found

In an interview on 8/30/19 at 8:43 AM, the Administrator said if someone had an ongoing problem like a yeast infection, they normally expected it to show up on the care plan. She added that a skin care plan had been added to the care plan as of yesterday.

It was determined the facility failed to ensure residents were appropriately assessed and monitored to prevent degeneration of skin surfaces and development of vascular issues. Therefore, the allegation was substantiated, and deficient practice was cited at F657 and F684.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

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,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj