IDAHO DEPARTMENT OF HEALTH & WELFARE

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September 8, 2006

Louis Kramel, Administrator
Bingham Extended Care Facility
98 Poplar Street
Blackfoot, ID 83221

Provider #: 135007

Dear Mr. Kramel:

On **July 14, 2006**, a Complaint Investigation was conducted at Bingham Extended Care Facility. Marcia Key, R.N. and Winifred Young, R.N. conducted the complaint investigation. A total of 14 survey hours were required to complete this investigation. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00001557

ALLEGATION #1:

An identified resident was dropped when she was being put to bed because staff was supposed to have two aides to transfer her. Only one aide transferred the resident. The resident suffered several injuries, thigh fracture and rib fracture. She later died from these injuries.

FINDINGS:

The survey team reviewed the Incident and Accident investigation report completed by the facility regarding the identified resident. The Administrative staff and direct care staff were also interviewed.

The facility thoroughly investigated the fall and determined the fall was not due to staff error or neglect. This was also the determination of the survey complaint team.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated a second identified resident requested that an unidentified staff member place the resident's pants on the bed so the resident could have access to his wallet. The aide refused four times. The resident's keys and wallet were later missing. The items were found but the resident's money was missing.

The complainant also stated this identified resident indicated that aides would come into his room and tell the resident they needed to borrow clothes for other residents who arrived from the hospital. The staff took some of the resident's clothes and they were not returned.

FINDINGS:

The Administrator, Director of Nursing, and the Social Services Director were interviewed. They stated they had spoken with the identified resident regarding the missing items and were able to resolve the situation to the satisfaction of the resident. The resident was interviewed and he also indicated he was satisfied with the outcome. The resident could not give the specific time period or name of the staff member who allegedly refused to place the clothes in the requested location. Direct care staff was interviewed. Each staff member denied refusing the resident's request. Each staff member also indicated they had not heard about the allegation from the resident or other staff.

The facility's grievance and resident council minutes were reviewed. There were no identified concerns from residents or family regarding borrowed clothing. The direct care staff on duty during the investigation and the laundry supervisor was interviewed. Each person stated the facility has a large storage area for clean, donated clothing which is available for residents. Each staff was able to identify the location of the storage area. They also indicated that staff does not borrow clothing from other residents. The laundry supervisor stated that on one occasion, approximately one year ago, she accidentally placed the identified resident's clothing in a second resident's room. A staff person informed her of this and she immediately corrected the problem. She also stated that approximately three to four weeks ago the identified resident's family member could not find the resident's "Mickey Mouse shirt." The shirt was found in the resident's closet the same day. The laundry supervisor stated the laundry staff does not enter residents' rooms to remove clothing. They only return laundered clothing to the residents' rooms. She indicated she would know if other residents were wearing his clothes. She indicated the resident and family had not mentioned this concern to her.

The Administrator and Director of Nursing were interviewed. They indicated they often speak with the resident and family. There have been no formal or informal concerns brought to their attention regarding staff borrowing his clothes for other residents.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

MARCIA KEY, R.N.
Health Facility Surveyor
Long Term Care

MK/dmj