



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

FILE COPY

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

March 13, 2015

Betty L. Van Gheluwe, Administrator
St Luke's Elmore Long Term Care
895 North 6th East, PO Box 1270
Mountain Home, ID 83647-1270

Provider #: 135006

Dear Ms. Van Gheluwe:

On **February 27, 2015**, a Recertification and State Licensure survey was conducted at St Luke's Elmore Long Term Care 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 and a similar State Form 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" (listed on page 2). **Please provide ONLY ONE completion date for each federal and state tag 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 both the Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and

Betty L. Van Gheluwe, Administrator
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return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 26, 2015**. Failure to submit an acceptable PoC by **March 26, 2015**, may result in the imposition of civil monetary penalties by **April 15, 2015**.

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 both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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 **April 3, 2015 (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 **April 3, 2015**. A change in the seriousness of the deficiencies on **April 3, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 3, 2015** includes the following:

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Denial of payment for new admissions effective **May 27, 2015**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 27, 2015**, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, Option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **February 27, 2015** 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 noncompliance 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>

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

- BFS Letters (06/30/11)

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

This request must be received by **March 26, 2015**. If your request for informal dispute resolution is received after **March 26, 2015**, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option 2.

Sincerely,

A handwritten signature in black ink that reads "Nina Sanderson, L.S.W." The signature is written in a cursive style.

NINA SANDERSON, L.S.W., Supervisor
Long Term Care

NS/dmj
Enclosures

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

PRINTED: 03/12/2015
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135006	(X2) MULTIPLE CONSTRUCTION A. <u>BUILDING</u> ----- B. WING	(X3) DATE SURVEY COMPLETED 02/27/2015
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NAME OF PROVIDER OR SUPPLIER ST LUKE'S ELMORE LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 895 NORTH 6TH EAST MOUNTAIN HOME, ID 83647
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification survey of your facility.</p> <p>The survey team entered the facility on Monday, 2/23/15, and exited the facility on Friday, 2/27/15.</p> <p>The surveyors conducting the survey were:</p> <p>Lauren Hoard, RN, BSN, Team Coordinator Karen Marshall, MS, RD, LD Becka Watkins, RN</p> <p>Survey Definitions:</p> <p>ADL = Activities of Daily Living A-fib = Atrial Fibrillation CM = Centimeter DON = Director of Nursing MARIMR = Medication Administration Record/Medication Record MDS = Minimum Data Set assessment MG = Milligrams PO= By Mouth POC = Plan of Care PRN = As Needed RN = Registered Nurse Tab= Tablet TID =Three Times a Day</p>	F 000		
F 153 SS=C	<p>483.10(b)(2) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS</p> <p>The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours</p>	F 153	<p><u>F 153</u></p> <p>Corrective actions accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> The language in the Long Term Care Handbook has been revised to comply with 	<p>April 3, 2015</p>

RECEIVED
MAR 26 2015
FACILITY STANDARDS

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE <i>Betty Van Theluwe</i>	TITLE <i>Administrator St. Luke's Elmore Long Term Care</i>	(X6) DATE <i>3/25/15</i>
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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 153	<p>Continued From page 1 (excluding weekends and holidays); and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the Long Term Care Handbook and staff interview, it was determined the facility failed to ensure residents understood their right to view their entire medical record when requested. This was true for 7 of 7 sampled residents (#s 1-7), and all other residents residing in the facility. This created the potential for psychological harm if residents were confused as to which portions of their medical record they could view. Findings included:</p> <p>The first section of the facility's Long Term Care Handbook contained a Notice of Privacy Practice, dated 4/14/03, which documented, "THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY...4. Your Rights Concerning Your Protected Health Information...Right to Inspect and Copy Records. You have the right to inspect and obtain a copy of your protected health information that is used to make decisions about your care, including medical and billing records. You may access your protected health information by submitting a completed Authorization form to the Privacy Officer in Health Information Management Services. We may charge you a reasonable</p>	F 153	<p>F 153 Continued From page 1 guidance in 483.10(b)(2). See attachment F 153-1.</p> <ul style="list-style-type: none"> •A new revised Long Term Care Handbook will be given to current residents/responsible party. •All old handbooks without revision date of 03/20/15 will be removed from inventory and disposed of. <p>Other residents having the potential to be affected by same deficient practice and corrective actions taken:</p> <p>This has the potential to affect current residents that reside in the facility and the following corrective actions have been taken:</p> <ul style="list-style-type: none"> •Revision of LTC Handbook and language revised to comply with guidance in 483.10(b)(2). <p>Measures that will be put into place and changes made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> •Long Term Care Handbook has been revised 03/20/15 to include language compliant with guidance. •New handbooks have been given to all current residents and/or responsible party. •All old handbooks have been removed from inventory and disposed of. <p>Corrective actions will be monitored to ensure the deficient practice does not recur:</p> <ul style="list-style-type: none"> •Updated handbooks with revision date of 3/20/15 will be kept in inventory and distributed. MDS Coordinator is responsible for monitoring for ongoing compliance and will monitor handbooks during each admission process for the next 30 days. Random audits will be conducted for the next 60 days. Results of the audit will be shared with the Quality Improvement Committee for further review and recommendations as related to the action 	

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F 153	<p>Continued From page 2</p> <p>cost-based fee for providing records to you. We may deny your request if you seek psychotherapy notes; information compiled in anticipation of legal proceedings; information that is protected by applicable law; and information that may result in substantial harm to you or others if disclosed."</p> <p>Further back into the facility's Long Term Care Handbook contained the Resident's Bill of Rights which included, "...2. The resident or legal representative has the right: To access all records pertaining to themselves within 24 hours (excluding weekends and holidays). To purchase, after receipt at a cost not to exceed the community standard, photocopies of the records or any portion of them within 2 working days of advance notice to facility management."</p> <p>On 2/24/15 at 1:15PM, the DON was interviewed. She verified the Long Term Handbook was the admission packet residents and/or resident representatives received. She said the process when residents wanted to view their medical record was that they had to sign a release form, then someone would sit with the resident and go over the information/record with them. The Notice of Privacy Practice was written regarding HIPAA (Health Insurance Portability and Accountability Act), and the DON acknowledged it was confusing when compared to the Resident's Bill of Rights. She said she would allow a resident to view any aspect of their medical record. The DON was made aware of the concern related to conflicting information in the Long Term Care Handbook.</p> <p>On 2/26/15 at 12:50 PM, the Administrator provided additional information. However, it did not resolve the issue.</p>	F 153	<p>F 153 Continued From page 2</p> <p>needed based on the outcome of the audit. DNS will be responsible for action plan as needed. See attachment F153-2.</p>	

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F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure dignity was provided during dining. This affected 2 of 4 residents (#s 6 & 11) observed receiving medications during the meal service. This practice created the potential to negatively affect the residents' dining experience. Findings included:</p> <p>1. Resident #6 was admitted to the facility with multiple diagnoses including A-fib and osteoporosis.</p> <p>The resident's 1/10/15 admission MDS coded cognitively intact and diagnoses of A-fib and osteoporosis.</p> <p>The resident's February 2015 Physician Orders (recapitulation) included orders for calcium 500mg, Vitamin D 200 MG Tab PO TID for osteoporosis and amiodarone 200 MG PO TID for A-fib.</p> <p>The resident's January 2015 POC did not include interventions or reasons for medications to be administered during dining.</p> <p>2. Resident #11 was admitted to the facility with multiple diagnosis including A-fib and pneumonia.</p>	F 241	<p>F 241</p> <p>Corrective actions accomplished for those residents found to have been affected by the deficient practice: Residents #6 and #11 were affected by practice. The staff involved with the incident was counseled to determine the causative factors for administering medications in the dining room. During the April 2, 2015 staff meeting, the DNS will remind all licensed nursing staff to not administer medication in the dining room.</p> <p>Other residents having the potential to be affected by same deficient practice and corrective actions taken: This has the potential to affect current residents residing in the facility and the following corrective actions will be taken: •Agenda item on the April 2, 2015 Licensed Nurse Meeting to educate on dignity and respect of individuality of residents and how administering medications in the dining room relates to this. See attachment F241-1.</p> <p>Measures that will be put into place and changes made to ensure that the deficient practice does not recur: •DNS to educate staff and monitor for compliance with not passing medication in the dining room.</p> <p>Corrective actions will be monitored to ensure the deficient practice does not recur: To assure medications are not given in the dining room, DNS will perform audits 2x week x 3 months. When compliance is achieved within this time frame, quarterly reviews will be done during the mock surveys. Results will be reported to the Quality Improvement Committee for further review and recommendations as related to the action needed based on the outcome of the audit. See attachment F241-2.</p>	April 3, 2015

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F 241	<p>Continued From page 4</p> <p>The resident's most recent 1/22/15 quarterly MDS coded moderately impaired cognition.</p> <p>The resident's February 2015 Physician Orders (recapitulation) included an order for Verapamil 60 MG PO every 6 hours for A-fib.</p> <p>The resident's January 2015 POC did not include interventions or reasons for medications to be administered during dining.</p> <p>On 2/23/15 at 11:55 a.m., the lunch meal service and resident dining was in progress. The following was observed:</p> <p>-At 12:00 p.m., RN #1 administered medications to Resident #6. RN #1 stated, "I gave [Resident #6] calcium and amiodarone. The amiodarone is for A-fib."</p> <p>-At 12:05 p.m., RN #1 administered a medication to Resident#11. At 12:10 p.m., the resident's 2/15 MAR was reviewed and documented Verapamil was the only medication administered at 12:00 p.m.</p> <p>During an interview on 2/26/15 at 2:00 p.m., the DON said the practice of administering medications after the meal service began was "not acceptable" and, unless there was a specific reason, medications should not be passed during meals.</p> <p>During a follow-up interview on 2/26/15 at 3:10 p.m., the MDS Coordinator reviewed Resident #6 & Resident #11's POCs and said neither resident was care planned to receive medications during dining.</p>	F 241		

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F 241	Continued From page 5	F 241		
F 309 SS=D	<p>On 2/27/15 at 11:00 a.m., the Administrator was informed of the finding.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and record review, it was determined the facility failed to ensure a resident's pain was addressed prior to a dressing change, and skin tears were prevented while removing a dressing. This was true for 1 of 3 sampled residents (#1). These failures created the potential for the residents to experience increased pain, complications and/or compromised medical or psychosocial status. Findings included:</p> <p>Resident #1 was readmitted to the facility on 11/21/14 with multiple diagnoses which included quadriplegia and a pressure ulcer to the buttock.</p> <p>The most recent annual MDS assessment, dated 11/27/14, documented Resident #1 was cognitively intact with a BIMS of 15, and required extensive assistance with bed mobility, transfers and personal hygiene. The resident had one Stage II pressure ulcer which was present on</p>	F 309	<p>F 309</p> <p>Corrective actions accomplished for those residents found to have been affected by the deficient practice: Resident #1 was identified on 02/26/15 as having increased pain and physician came to evaluate and increased dosage of Neurontin and Fentanyl Patch. Frequent medication changes were made to address pain and anxiety with multiple diagnostic tests to rule out sepsis or infection. Patient evaluated at Pain Clinic on 03/06/15 and 03/09/15. The skin tear healed without complications by 03/05/15.</p> <p>In spite of interventions including increase in dosage of morphine and baclofen pump the resident condition declined resulting in an admission to hospital on 03/16/15. The resident was discharged from the hospital to a long term acute hospital which was determined to be the appropriate level of care.</p> <p>Other residents having the potential to be affected by same deficient practice and corrective actions taken: This has the potential to affect current residents who reside in the facility that receive dressing changes. The following corrective action will be taken: •Staff meeting on April 2, 2015 will include review and discussion of Pain Management Policy with emphasis on reassessment and intervention. Will review that skin issues can be related to adhesives and a process in needed to remove adhesives prior to</p>	April 3, 2015

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F 309	<p>Continued From page 6</p> <p>admit. The resident experienced pain frequently, which did not effect sleep or day-to-day activities, and was on a scheduled pain medication regimen with PRN pain medications and non-medication interventions.</p> <p>Resident #4's Care Plan, dated 12/5/14, documented the problem of at risk for pain related to quadraparesis [sic]-C5 incomplete fracture, myalgia and myositis, baclofen pump replaced on 11/18/14, extensive/dependent ADL assist, spastic movements and verbal outburst second to back pain at times. The interventions included, "Assist with mobility & transfers as per POC [Plan of Care]; Ensure proper body alignment when in w/c or bed; Provide gentle ROM [Range of Motion] with daily cares; Rest periods as needed throughout [sic] the day; Encourage & escort to activities of choice; Provide pain medications as ordered and prn; Assess effects/side effects of medications; Report to the MD as indicated."</p> <p>The resident's Care Plan, dated 12/5/13, also documented the problem of left ischial tuberosity Stage II wound pressure ulcer. The interventions included, "2/5/15....1increase time up to 4 [hours per] day in w/c...cont. off loading..."</p> <p>Resident #1's February 2015 recapitulated Physician's Orders included orders for Gabapentin 600 mg by mouth twice per day for neuropathy (2/18/14), Internal Baclofen Pump (7/15/14), Tylenol 650 mg by mouth every 6 hours as needed for pain (1/16/14), and Norco 5/325 mg by mouth 1 tablet for moderate pain, 2 tablets for severe pain every 6 hours as needed for pain (1/30/15).</p>	F 309	<p>F 309 Continued From page 6</p> <p>removing the dressing. See attachment F241-1.</p> <p>Measures that will be put into place and changes made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> •Evaluation will be added to documentation of the dressing change to include resident comfort level. •Will add task to monthly chart audits to include documentation of resident comfort during dressing changes. •Will continue to investigate causes for skin impairments and identify those caused by adhesive and will intervene with staff involved and develop an action plan for improvement. See attachments F309-1 and F309-2. <p>Corrective actions will be monitored to ensure the deficient practice does not recur:</p> <ul style="list-style-type: none"> • DNS will audit for documentation of resident comfort during dressing changes 2 times weekly X 3 months and add to quarterly mock survey. See attachment F309-3. • If causative factor of skin impairment is related to adhesive, an action plan for improvement will be developed. <p>DNS is responsible for overall compliance and monitoring.</p>		

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F 309	<p>Continued From page 7</p> <p>On 2/24/15 at 3:00PM, the surveyor requested to observe Resident #1's pressure ulcer the following day (2/25/15) and to inform that day's LN so that she would not have to do 2 dressing changes.</p> <p>On 2/25/15 at 10:00 AM, a dressing change to Resident #1's buttock was observed with the DON and LN #2 present. The resident was laying on his back in bed and complained of severe back pain. As the dressing change began, the resident yelled, "Ow," and, "Oh, it burns" as he flailed/shook his arms around. As LN #2 pulled the dressing off of the resident's buttock, an area underneath the adhesive portion of the dressing began bleeding as skin came off with it. The resident yelled, "You guys are pulling my skin off," and the LN continued to remove the dressing. The LN said the resident must have had some shearing near the pressure ulcer, which was not noted when she did the dressing change earlier that day. The area was cleansed and a new dressing was placed over the pressure ulcer and new open area/skin tear. At 10:09 AM the DON said she would call the physician for an extra pain medication. The resident had been medicated with Norco at 6:30AM that day, and it was not available again until 12:30 PM. After the surveyors left the room, the resident was overheard yelling of pain inside his room with the door closed.</p> <p>A Nurse's Note for Resident #1, dated 2/25/15, documented, "(1104) Skin tear discovered during wound care 1.5 x 1 em in size on left IT [ischial tuberosity]. Cleanse and dressed per standing orders. Resident has unresolved pain and began having anxiety; PRN Ativan given 1025 [10:25 AM] and [Physician's name] called, reviewed new</p>	F 309		

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F 309	<p>Continued From page 8</p> <p>orders to follow standing orders on skin tear and to increase Gabapentin 600 mg tid po [three times per day by mouth] for pain. Staff repositioned multiple times, 1:1, and offered drinks and tried to help [with] relaxation [with] no success. Second dose of Gabapentin given will continue to monitor."</p> <p>Resident #1's Skin Impairment form, dated 2/25/15, documented a skin tear to the left ischial tuberosity measuring 1.5 x 1 em which was discovered during a dressing change, caused pain, and not well tolerated.</p> <p>On 2/25/15 at 1:00PM, the DON said she had seen the dressing changed many times by LN #2 and it had never gone like that. She said the dressing removed during the observation was put on after the resident's shower, and the tape may have been more sticky than usual.</p> <p>On 2/25/15 at 1:26 PM, LN #2 was interviewed about the dressing change for Resident #1. When asked if the dressing change usually caused the resident so much pain, the LN stated, "No," and he was possibly overstimulated as he did not want to lay down. Usually it was a quick get in and get out, and that was it. The LN was asked why the dressing change was continued when the resident was complaining of back pain, and she said she did stop to try and allow the resident to refocus. When asked why she continued to pull off the dressing when skin was coming off with it, she stated, "I stopped it" for a few minutes. She clarified that a "few minutes" meant "a little bit." The LN was asked how she used the normal saline to soak the dressing prior to removing it as this was not observed by the surveyor. The LN explained she put normal saline on gauze and</p>	F 309		
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F 309	<p>Continued From page 9</p> <p>rubbed the gauze along the adhesive to get it loose, repositioned the resident, then removed the dressing.</p> <p>On 2/25/15 at 2:15 PM, LN #2 was again interviewed and asked about pain and skin tear management after the dressing change. The LN said she called the physician and reported the pain, but the physician did not want to do another Norco. Instead, the resident's gabapentin was increased and administered. The resident then required an Ativan to calm down. When asked why the resident was laid down when he didn't want to, the LN stated, "I needed to do the dressing" and thought it would be quick. The LN reported the resident said, "Ok." When asked why the dressing was changed twice, the LN stated, "Because I was told you wanted to see it." The LN said she was informed during report that the surveyors wanted to watch the dressing change, but the resident was having bad back pain and she thought a warm shower might provide relief.</p> <p>On 2/26/15 at 9:00 AM, Resident #1 was interviewed about the dressing change from the previous day. He said sometimes the dressing change caused pain, mostly when the dressing was pulled off. He said he had a lot of back pain while laying down and the dressing change added to it. The resident was asked what would provide pain relief, and he said pulling the dressing off slower and easier.</p> <p>Resident #1 was complaining of pain prior to the dressing change, but the procedure continued. Removal of the old dressing took skin off with it and increased the resident's pain, but the procedure continued, and normal saline was not</p>	F 309		
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F 309	Continued From page 10 used to assist with removing the adhesive from the resident's skin. The resident required an antianxiety medication afterwards to calm down.	F 309		
F 329 SS=D	483.25(1) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329	<u>F329</u> Corrective actions accomplished for those residents found to have been affected by the deficient practice: Resident #4 was affected by this practice. The resident care plan was reviewed and target behaviors identified and interventions for those behaviors were added. Resident #4 was reviewed at the 3/25/15 Resident at Risk Meeting. See attachment F329-1. Other residents having the potential to be affected by same deficient practice and corrective actions taken: This has the potential to affect current residents residing in the facility receiving psychotropic medication and the following corrective actions will be taken: •Residents having behaviors will be scheduled for the Resident at Risk meeting to assure the care plan and behavior monitors reflect accurate target behaviors and interventions. •The Licensed Social Worker will review behavior monitors and care plans for residents on psychotropic medications and sign off on both documents monthly.	April 3, 2015

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F 329	<p>Continued From page 11</p> <p>by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure a resident receiving antipsychotic medication had adequate indications for it's use, adequate monitoring and care planning. This was true for 1 of 4 sampled residents (#4). This practice placed residents at risk for unanticipated declines or newly emerging or worsening symptoms. Findings included:</p> <p>Resident #4 was admitted to the facility on 2/27/14 with multiple diagnoses which included dementia without behavioral disturbance.</p> <p>The most recent significant change MDS assessment, dated 12/2/14, documented Resident #4 was severely cognitively impaired, had hallucinations, delusions, physical behavioral symptoms directed towards others 1-3 days, and wandering which occurred 4-6 days but less than daily. The resident received an antipsychotic medications 7 days out of the preceding 7 days.</p> <p>Resident #4's Care Plan, dated 12/9/14, documented the resident was at risk for mood/behavior issues, but there was no documentation as to what the risk was related to. The goal documented, "[Resident's name] will not have any unresolved mood/behavior issues by:" and no date was provided. The interventions included, "Orient to place as appropriate; speak clearly and increase volume when talking with [Resident's name]; Respect end of life wishes r/t DNR/DNI status; Encourage him to participate in activities he enjoys, especially working in the garden when the weather gets warmer; Due to confusion, allow appropriate interaction with female staff and residents, but re-direct if he</p>	F 329	<p>F 329 Continued From page 11</p> <p>Measures that will be put into place and changes made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> Residents on psychotropic medications will be reviewed including care plans and behavior monitors no less than monthly by a Licensed Social Worker. See attachments F329-2 and F329-3 <p>Corrective actions will be monitored to ensure the deficient practice does not recur:</p> <ul style="list-style-type: none"> DNS will track residents that have psychotropic medications ordered Utilizing Medication Recapitulation to ensure residents are scheduled on the Resident At Risk Committee schedule. 	
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F 329	<p>Continued From page 12 attempts inappropriate interactions."</p> <p>An additional problem area identified on Resident #4's Care Plan, dated 12/9/15, included Psychotropic Drugs with interventions which included, "Meds as ordered; Bring to quarterly psychotropic med reviews; Monitor for side effects and report to physician; Enter behaviours [sic] on monitor."</p> <p>The February 2015 recapitulated Physician's Orders for Resident #4 included an order for Haldol 2 mg by mouth daily at 2:00 PM with the diagnosis, "Sundowning with agitation." The medication was started on 12/4/14.</p> <p>Resident #4's February 2015 MAR documented the resident received the antipsychotic as ordered for sundowning with agitation.</p> <p>A Long Term Progress Note for Resident #4, dated 12/4/14, documented, "The patient continues to have the desire to leave the facility to go back to his home...He does have moderately severe senile dementia and has had significant behaviors which were disruptive of staff and residents...PLAN: 1. We are having our psychotropic committee meeting later this afternoon and will discuss the medication which the patient is receiving on a monthly basis to help regulate his agitation and behavioral issues due to his dementia."</p> <p>A Behavioral/Psychopharmacological Review for Resident #4, dated 12/4/14, documented, "Haldol 2 mg Daily at 1600 [4:00PM] Ox [Diagnosis] Sundowning [with] Agitation" as the psychotropic medication and prescribing diagnosis. The form asked if the resident continued to exhibit target</p>	F 329		
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F 329	<p>Continued From page 13</p> <p>behaviors, and "yes (describe behaviors to include non-medicinal interventions that have failed)" was check marked, with the hand written description, "wanting to leave - 4 times Exit seeking."</p> <p>The December 2014 Supplemental Behavior Monitoring Record for Resident #4 documented the behaviors, "Anxiety: perseverating about leaving-phoning-taking care of outside chores-etc," and, "sundowning."</p> <p>The January 2015 Behavior Monitor for Resident #4 documented the behaviors confusion, exit seeking, and repetitive requests. The Justifying Diagnosis for Haldol documented, "Dementia."</p> <p>The January 2015 Supplemental Behavior Monitoring Record documented the behavior, "sundowning- agitation."</p> <p>Resident #4's February 2015 Supplemental Behavior Monitoring Record documented the behavior, "Wanting to go home..."</p> <p>On 2/25/15 at 12:35 PM, the DON was interviewed regarding Resident #4 and the use of an antipsychotic medication. She said before the medication was started, the resident was seeing people in the parking lot, had agitation and was not able to retain information. The resident thought people were coming in the back door, had delusional hallucinations and paranoia. The DON said other methods attempted prior to the antipsychotic included an antianxiety medication, one on one (1:1), activities of walking outside or working on a garden made just for him. The 1:1 worked on a temporary basis, but did not work long-term. The resident had flight of thought with</p>	F 329		

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F 329	<p>Continued From page 14</p> <p>the 1:1 which increased his agitation. When asked about the underlying cause of the resident's behaviors, the DON stated, "I'm not really sure," the physician thought dementia with psychosis. The DON said they tried to get the family to come in, but it was a challenge as the resident wanted to be taken home. They tried to make the environment like that at home, changed room and roommates, which ultimately confused him more. The DON identified the target behavior treated with the antipsychotic medication as, "Repetitive inability to sit down." On one occasion the DON remembered the resident was up and down 34 times in a 2 hour timeframe. The staff tried to divert his attention and do a 1:1, but the resident had tears in his eyes as he was really bothered by his anxiety. The target behaviors monitored were anxiety, hours of sleep, repetitive and hallucinations. The DON was asked what the resident's care plan said about his behaviors. She read the mood/behavior care plan out loud and said, "I don't see it [repetitive movements] on here." When asked what the care plan said about his behaviors, she stated, "Nothing." The DON was asked which behaviors were currently monitored and she said sundowning/agitation. She said the resident should have one (behavior monitored) that was repetitive. The DON said Resident #4 was not receiving any medications for anxiety.</p> <p>Resident #4 was receiving an antipsychotic for sundowning with agitation. The Behavior Monitor documented the justifying diagnosis was dementia. It was unclear which target behavior was treated with the medication as each month from December 2014 to February 2015 was different, and hallucinations and delusions were not monitored. In addition, the care plan did not</p>	F 329		
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F 329	Continued From page 15 tell staff which behaviors the resident displayed, which ones to monitor for and what to do should the behavior(s) occur.	F329		
F 332 SS=D	<p>On 2/26/15 at 3:00PM, the Administrator and DON were informed of the antipsychotic concerns. No further information was provided.</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview record review, it was determined the facility failed to ensure it maintained a medication error rate less than 5 percent when medications were administered late, were not administered as directed on the MAR, and were not administered per manufacturer's recommendations. This was true for 20 of 25 medications (80%) during the medication pass observation which affected 2 of 4 random residents (#9 & 10) and 1 of 7 sampled residents (#6). This failure created the potential for the affected residents to receive less than optimum benefit from prescribed medications. Findings included: The facility's Policy for Medications, revised on 6/27/14, documented, "...J. Certain medications are to be given with or apart from food in order to enhance efficacy and minimize side effects...Administration...B. When administering medications, the following 'rights' of medication</p>	F 332	<p>F 332</p> <p>Corrective actions accomplished for those residents found to have been affected by the deficient practice: Residents # 6, #9 and #10 were affected by practice. Resident #6 see corrective actions outlined in F 241. Resident #9 see corrective actions in F 241; LTCU DNS counseled with Licensed Nurse involved to follow direction given to administer medications and to notify her if orders could not be followed as written and if there was a delay in administering medications outside of administration time frame. Resident #10 see corrective actions in F 241 and attachment F332-1; after discussion with both the Licensed Nurse involved and the resident it was determined that resident wanted to take medications after getting out of bed later in the morning. This resident will be care planned to take morning medications when she gets out of bed in the morning and her thyroid medication will be given on an empty stomach prior to breakfast. To account for the change in times the 7 am and 8 am medications will be scheduled for 9 am with an acceptable range of administration between 8 - 10 am with the thyroid medication given on an empty stomach prior to breakfast. Based on physician orders medications will be given at an appropriate time frame.</p> <p>Change MAR and individual care plans to reflect residents' preference with food or fluid choice with medication administration.</p>	April 3, 2015

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F 332	<p>Continued From page 16</p> <p>are to be followed: 1. Right patient...2. Right medication...3. Right dose 4. Right time 5. Right route...6. Right Documentation..."</p> <p>1. Resident #9's recapitulated Physician's Orders for February 2015, included orders for Norvasc 2.5 mg by mouth daily for hypertension, Lisinopril 20 mg by mouth daily for hypertension, Spironolactone 50 mg by mouth daily for hypertension, Omeprazole 20 mg by mouth daily for GERD (gastroesophageal reflux disease), Atorvastatin 40 mg by mouth daily for hyperlipidemia, Aspirin 81 mg with apple juice by mouth daily for CVA (cerebrovascular accident), Oxybutynin ER (extended release) 10 mg by mouth daily for neurogenic bladder, Multivitamin with minerals by mouth daily for nutritional supplement, Docusate Sodium 100 mg by mouth two times per day for constipation, Wellbutrin 75 mg by mouth daily for depression, and Miralax 17 grams dissolve in water or juice by mouth daily for constipation.</p> <p>The February 2015 MAR for Resident #9 documented the aforementioned medications were to be administered at 7:00AM.</p> <p>On 2/24/15 at 9:00AM, LN #1 was observed to pour and administer Norvasc, Lisinopril, Spironolactone, Omeprazole, Atorvastatin, Aspirin, Oxybutynin, Multivitamin, Docusate Sodium, Wellbutrin, and Miralax for Resident #9, 2 hours after it was scheduled to be administered, or 1 hour past the 1 hour window. The Miralax was mixed in a small plastic cup and was used by the resident to swallow the medications. Apple juice was not provided with the Aspirin as directed on the orders and MAR.</p>	F 332	<p>F 332 Continued From page 16</p> <p>Other residents having the potential to be affected by same deficient practice and corrective actions taken: This has the potential to affect current residents who receive medications residing in the facility and the following corrective actions will be taken: •For residents taking thyroid medication, the Medication Administration Record (MAR) will have direction to give medication on empty stomach prior to first meal of the day. •Residents receiving Miralax will have direction to give medication mixing in 8 ounces (240 ml) of water, juice, soda, coffee or tea based on physician orders. See attachment F332-2. •Resident MARs will be reviewed to determine which residents prefer to get up late in the morning and if the scheduled time would put them at risk for getting their medications late. Those residents identified as being late risers in the morning will have their 7-8 am medications changed to 10 am if appropriate for medication.</p> <p>Measures that will be put into place and changes made to ensure that the deficient practice does not recur: •If resident is taking a medication that requires it be given on an empty stomach prior to meals, it will be designated on the pocket care plan. Staff will be educated to be aware of residents that have special needs associated with medication. •Will develop a workgroup to look at medication administration process in our unit and identify practices to determine how resident needs can be met by giving medications within a range of time especially in the morning when a resident may request a late breakfast or to not be awakened until a designated time.</p>	
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F 332	<p>Continued From page 17</p> <p>On 2/24/15 at 9:24AM, LN #1 was asked how many ounces of fluid Miralax was to be mixed with, and she stated, "Probably about 6 to 8 ounces." When asked how many ounces the small plastic cups held, the LN stated, "About 4." LN #1 was asked about the lack of apple juice with the administration of Aspirin, and she said Resident #9 did not usually like apple juice, and did not drink juices in the morning.</p> <p>The Nursing 2014 Drug Handbook, page 1123 for Miralax, states: "Dissolve powder in 8 ounces (240 ml) of water, juice, soda, coffee, or tea."</p> <p>2. Resident #10's recapitulated Physician's Orders for February 2015, included orders for Calcitonin spray alternate nostrils daily for osteoporosis, Calcium 500 Vitamin D 200 by mouth three times per day for osteoporosis, Lidoderm 5% topical patch to skin x 12 hours daily to painful area on back, Symbicort 160/4.5 1 puff inhaled twice per day for COPD (Chronic Obstructive Pulmonary Disease), Synthroid 50 meg (micrograms) by mouth daily for hypothyroidism, Nicotine Patch 14 mg daily to skin for tobacco cessation, Docusate Sodium 100 mg by mouth twice per day for stool softener, Spiriva 1 capsule inhaled daily for COPD, and Simvastatin 20 mg by mouth daily for hypercholesterolemia.</p> <p>The February 2015 MAR for Resident #10 documented the aforementioned medications were to be administered at 7:00AM.</p> <p>On 2/24/15 at 9:15AM, LN #1 was observed to pour and administer Calcitonin spray, Calcium Vitamin D, Lidoderm patch, Symbicort,</p>	F 332	<p>F 332 Continued From page 17</p> <p>Until there are recommendations from the workgroup each resident will be looked at individually to determine when morning medications should be scheduled.</p> <p>Corrective actions will be monitored to ensure the deficient practice does not recur:</p> <ul style="list-style-type: none"> • Each month and upon admission the Unit Clerk will review medication record and recapitulations prior to printing to ensure direction is given regarding thyroid medication and Miralax. If direction is absent the Unit Clerk will notify DNS prior to printing documents. • The DNS and MDS Coordinator will review care plans and MAR for each resident and ensure direction is given for times of medication administration for those residents who have personal preferences that would put them at risk to receive medications later than scheduled. 	

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

PRINTED: 03/12/2015
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/27/2015
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NAME OF PROVIDER OR SUPPLIER ST LUKE'S ELMORE LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 895 NORTH 6TH EAST MOUNTAIN HOME, ID 83647
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F 332	<p>Continued From page 18</p> <p>Synthroid, Nicotine Patch, Docusate Sodium, Spiriva, and Simvastatin for Resident #10, 2 hours and 15 minutes after it was scheduled to be administered, or 1 hour and 15 minutes past the 1 hour window. The LN was asked if the resident had eaten breakfast already, and she said the resident had a little breakfast in her room.</p> <p>On 2/24/15 at 9:24 AM, LN #1 was asked when Synthroid should be administered, and she stated, "Probably before breakfast. The time should be changed because there is no guarantee of getting it before breakfast."</p> <p>The Nursing 2014 Drug Handbook, page 829 for Synthroid, states: "Give drug at same time each day on an empty stomach, preferably 1/2 to 1 hour before breakfast."</p> <p>On 2/24/15 at 9:24 AM, LN #1 was also asked about the medications administered late for Resident #9 and #10. She said with the volume of residents she could not get all of the 7:00AM medications passed at that time.</p> <p>On 2/26/15 at 1:50PM, the DON said she was aware some medications were late, but not as late as what the surveyor observed. She said it was very unusual as usually the medication pass is done by 8:30AM. The DON clarified the 1 hour window was 1 hour before and 1 hour after the scheduled time.</p> <p>On 2/26/15 at 3:00 PM, the Administrator and DON were informed of the medication administration concerns. No further information was provided.</p>	F 332		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=D	<p>Continued From page 19 SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p><u>F 441</u></p> <p>Corrective actions accomplished for those residents found to have been affected by the deficient practice: Resident #1 was affected by practice. The staff involved was counseled regarding survey observations and hand hygiene during a dressing change at the time of occurrence.</p> <p>Other residents having the potential to be affected by same deficient practice and corrective actions taken: This has the potential to affect all residents in the facility receiving a dressing change and the following corrective actions will be taken: •Health Safety and Infection Prevention Nurse will attend April 2, 2015 Licensed Nurse Staff Meeting to educate and remind staff about correct hand washing procedure during dressing changes.</p> <p>Measures that will be put into place and changes made to ensure that the deficient practice does not recur: •The LTCU DNS will observe dressing change weekly x 4 weeks and determine if compliance for hand washing is followed. If there is compliance, observation of dressing change will be added to task during quarterly mock survey.</p> <p>Corrective actions will be monitored to ensure the deficient practice does not recur: •Observe dressing change weekly x 4 weeks. If compliance achieved add dressing change to mock survey task list and evaluate compliance quarterly.</p>	April 3, 2015

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F 441	<p>Continued From page 20</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and Policy & Procedure review, it was determined the facility failed to ensure nursing staff performed hand hygiene during a dressing change. This was true for 1 of 7 sampled residents (#1). This deficient practice placed residents at risk for infections due to transmission of microorganisms. Findings included:</p> <p>The facility's Policy & Procedure for Infection Prevention, dated 3/31/14, documented, "PERSONAL HYGIENE...A. Indications for hand hygiene: 1. The World Health Organization's 5 moments of Hand Hygiene a. Before touching a patient b. Before a clean/aseptic procedure c. After body fluid exposure risk d. After touching a patient e. After touching patient surroundings 2. Upon entry and exit from patient rooms/bays. 3. Before and after donning gloves. 4. When hands are visibly soiled (requires soap and water). 5. After use of restroom, coughing or sneezing into hands, or contact with animals. 6. Before and after eating..."</p> <p>Resident #1 was readmitted to the facility on 11/21/14 with multiple diagnoses which included quadriplegia and a pressure ulcer to the buttock.</p> <p>The most recent annual MDS assessment, dated 11/27/14, documented Resident #1 was cognitively intact with a BIMS of 15, required extensive assistance for bed mobility, dressing and personal hygiene. The resident had 1 Stage II pressure ulcer present on admission to the facility.</p>	F 441		

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F 441	<p>Continued From page 21</p> <p>On 2/25/15 at 10:00 AM, a dressing change was observed for Resident #1 with LN #2 and the DON present. LN #2 was observed to remove the soiled dressing from the resident's buttock and managed bleeding from a wound. Without removing her bloody gloves and performing hand hygiene, the LN placed the new clean dressing over the wound. After placing the new dressing, the LN removed her left glove and donned a new clean glove without performing hand hygiene. The LN assisted the DON with turning the resident side to side to place a clean chux underneath the resident, all while wearing the same dirty bloody glove on her right hand. After the clean chux was in place, the LN touched the resident's bedding, pillows, the bedside table. She removed her gloves and donned a clean pair without performing hand hygiene. The LN proceeded to clean her scissors with a wipe, removed her gloves and performed hand hygiene.</p> <p>On 2/25/15 at 10:09 AM, LN #2 was asked if she changed her gloves after removing the soiled dressing, and she stated, "No." When asked if she washed her hands between glove changes, the LN stated, "No. I know I was supposed to, I'm sorry."</p> <p>On 2/26/15 at 3:00 PM, the Administrator and DON were informed of the lack of hand hygiene concern. No further information was provided.</p>	F 441		

Bureau of Facility Standards

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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the State licensure survey of your facility. The survey team entered the facility on Monday, 2/23/15, and exited the facility on Friday, 2/27/15. The surveyors conducting the survey were: Lauren Hoard, RN, BSN, Team Coordinator Karen Marshall, MS, ROE, LD Becka Watkins, RN Survey Definitions: DOH = Date of Hire DON = Director of Nursing	C000		
C 099	02.009 CRIMINAL HISTORY AND BACKGROUND CHECK REQUIRE 01. Criminal History and Background Check. A skilled nursing and intermediate care facility must complete a criminal history and background check on employees and contractors hired or contracted with after October 1, 2007, who have direct patient access to residents in the skilled nursing and intermediate care facility. A Department check conducted under IDAPA 16.05.06, "Criminal History and Background Checks," satisfies this requirement. Other criminal history and background checks may be accepted provided they meet the criteria in Subsection 009.02 of this rule and the entity conducting the check issues written findings. The entity must provide a copy of these written findings to both the facility and the employee. (3-26-08) 02. Scope of a Criminal History and Background	C099	C099 Corrective actions accomplished for those residents found to have been affected by the deficient practice: •Staff A with DOH 02/09/15 fingerprint based criminal history and background check was completed on 03/20/15. •Staff B with DOH 11/24/14 fingerprint based criminal history and background check was completed on 03/06/15. Refer to attachments C099-1 and C099-2. Other residents having the potential to be affected by same deficient practice and corrective actions taken: This has the potential to affect current residents residing in the facility and the following corrective actions were taken: •The personnel files of all other employees and contractors who have direct patient access to Residents were reviewed to determine that fingerprint based criminal history and background checks were	RECEIVED MAR 26 2015 FACILITY STANDARDS April 3, 2015

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Betty Van Dyke* TITLE: *Administrator St. Luke's Elmore Long Term Care* (X6) DATE: *3/25/15*

STATE FORM 88DK711 If continuation sheet 1 of 4

Bureau of Facility Standards

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c 099	<p>Continued From page 1</p> <p>Check. The criminal history and background check must, at a minimum, be a fingerprint-based criminal history and background check that includes a search of the following record sources: (3-26-08)</p> <p>a. Federal Bureau of Investigation (FBI); (3-26-08)</p> <p>b. Idaho State Police Bureau of Criminal Identification; (3-26-08)</p> <p>c. Sexual Offender Registry; (3-26-08)</p> <p>d. Office of Inspector General List of Excluded Individuals and Entities; and (3-26-08)</p> <p>e. Nurse Aide Registry. (3-26-08)</p> <p>03. Availability to Work. Any direct patient access individual hired or contracted with on or after October 1, 2007, must self-disclose all arrests and convictions before having access to residents. The individual is allowed to only work under supervision until the criminal history and background check is completed. If a disqualifying crime as described in IDAPA 16.05.06, "Criminal History and Background Checks," is disclosed, the individual cannot have access to any resident. (3-26-08)</p> <p>04. Submission of Fingerprints. The individual's fingerprints must be submitted to the entity conducting the criminal history and background check within twenty-one (21) days of his date of hire. (3-26-08)</p> <p>05. New Criminal History and Background Check. An individual must have a criminal history and background check when: (3-26-08)</p> <p>a. Accepting employment with a new employer; and (3-26-08)</p> <p>b. His last criminal history and background check was completed more than three (3) years prior to</p>	c 099	<p>Continued From page 1</p> <p>completed upon hire. If not, a fingerprint based criminal history and background check will be completed.</p> <p>Measures that will be put into place and changes made to ensure that the deficient practice does not recur:</p> <p>•St. Luke's Elmore Long Term Care Unit decided that employees and contractors who have direct patient access to residents and hired or contracted after 10/01/07 will have a fingerprint based criminal history and background check upon hire even if one was completed previously within 3-years of hire.</p> <p>Corrective actions will be monitored to ensure the deficient practice does not recur:</p> <p>•Fingerprint based criminal history and background checks for employees and contractors who have direct access to residents will be monitored at the time of hire by Human Resources Staff and audited every other week for 3 months by the LTCU Administrator. If compliance is achieved audits will be decreased to quarterly.</p>	
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Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ST LUKE'S ELMORE LONG TERM CARE

895 NORTH 6TH EAST
MOUNTAIN HOME, ID 83647

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C 099	<p>Continued From page 2</p> <p>his date of hire. (3-26-08)</p> <p>06. Use of Criminal History Check Within Three Years of Completion. Any employer may use a previous criminal history and background check obtained under these rules if: (3-26-08)</p> <p>a. The individual has received a criminal history and background check within three (3) years of his date of hire; (3-26-08)</p> <p>b. The employer has documentation of the criminal history and background check findings; (3-26-08)</p> <p>c. The employer completes a state-only background check of the individual through the Idaho State Police Bureau of Criminal Identification, and (3-26-08)</p> <p>d. No disqualifying crimes are found. (3-26-08)</p> <p>07. Employer Discretion. The new employer, at its discretion, may require an individual to complete a criminal history and background check at any time, even if the individual has received a criminal history and background check within the three (3) years of his date of hire. (3-26-08)</p> <p>This Rule is not met as evidenced by: Based on review of staff personnel files and staff interview, it was determined the facility failed to ensure criminal history checks for staff were checked within 21 days of hire for 2 of 3 (A & B) staff reviewed for criminal history checks. The practice created the potential for residents to be placed at risk for abuse or neglect. Findings included:</p> <p>During an interview on 2/26/15 at 9:30a.m., the surveyor and the Human Resources Business</p>	C 099		
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c 099	<p>Continued From page 3</p> <p>Partner (HRBP) reviewed Staff A and Staff B's personnel files with the following results.</p> <p>-Staff A, DOH: 2/9/15. An Idaho Department of Health and Welfare letter, dated 2/20/15, that documented a background check was completed 8/1/13 with no disqualifying crimes revealed.</p> <p>-Staff B, DOH: 11/24/14. An Idaho Department of Health and Welfare letter, dated 11/21/14, that documented a background check was completed on 12/5/12 with no disqualifying crimes revealed.</p> <p>However, neither Staff A and Staff B's personnel files included documentation of a state-only background check through the Idaho State Police Bureau of Criminal Identification.</p> <p>The HRBP said the state-only background checks would be completed as soon as possible.</p> <p>On 2/27/15 at 11:00 a.m., the Administrator and the DON were informed of the finding.</p>	C099		
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