



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

February 25, 2016

Nolan Hoffer, Administrator
St Luke's Rehab - Elks Sub Acute Rehab Unit
600 North Robbins Road,
Boise, ID 83702-4565

Provider #: 135114

Dear Mr. Hoffer:

On **January 21, 2016**, a survey was conducted at your facility. You have alleged that the deficiencies cited on that survey will be corrected. We are accepting your Plan of Correction.

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,

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt



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February 2, 2016

Nolan Hoffer, Administrator
St Luke's Rehabilitation-- Elks Sub Acute Rehabilitation Unit
PO Box 1100
Boise, ID 83701-4539

Provider #: 135114

Dear Mr. Hoffer:

On January 21, 2016, a survey was conducted at St Luke's Rehabilitation - Elks Sub Acute Rehabilitation Unit by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

Nolan Hoffer, Administrator
February 2, 2016
Page 2 of 4

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 **February 15, 2016**. Failure to submit an acceptable PoC by **February 15, 2016**, may result in the imposition of civil monetary penalties by **March 6, 2016**.

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 **February 25, 2016 (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 **February 25, 2016**. A change in the seriousness of the deficiencies on **February 25, 2016**, may result in a change in the remedy.

Nolan Hoffer, Administrator
February 2, 2016
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **February 25, 2016** includes the following:

Denial of payment for new admissions effective **April 21, 2016**. [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 **July 21, 2016**, 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 **January 21, 2016** 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>

Nolan Hoffer, Administrator
February 2, 2016
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 **February 15, 2016**. If your request for informal dispute resolution is received after **February 15, 2016**, 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,



David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures



February 24, 2016

Loretta Todd
Idaho Department of Health and Welfare
Bureau of Facility Standards
3232 Elder Street
PO Box 83720
Boise, ID 83720

Re: St. Luke's Rehabilitation—Elks Sub Acute Rehabilitation Unit Provider # 135114

Dear Ms. Todd:

This letter is in follow-up to your communication with Nolan Hoffer and myself on February 24, 2016, related to the Plan of Correction that was submitted on February 19, 2016. We have reviewed your concerns and updated our Plan of Correction per your direction.

Enclosed you will find our updated Plan of Correction for tag F-431 as requested. Please replace these pages in our 2567 report.

Thank you for allowing us the opportunity to respond to your findings. If you have any questions or concerns, please feel free to contact me at (208) 381-9391.

Sincerely,

Jodi Brewster, BSN, RN, HACP
Director, Accreditation and Patient Relations

Cc: Nolan Hoffer
Enclosures

RECEIVED
FEB 24 2016

FACILITY STANDARDS



February 15, 2016

David Scott, RN, Supervisor
Idaho Department of Health and Welfare
Bureau of Facility Standards
3232 Elder Street
PO Box 83720
Boise, ID 83720

Re: St. Luke's Rehabilitation—Elks Sub Acute Rehabilitation Unit Provider # 135114

Dear Mr. Scott:

This letter is in follow-up to your correspondence and the Statement of Deficiencies dated February 2, 2016 advising us of your findings relative to the survey conducted at St. Luke's Rehabilitation – Elks Sub Acute Rehabilitation Unit on January 21, 2016.

Enclosed you will find our Plan of Correction describing procedures we have implemented in response to the processes cited as deficiencies.

Thank you for allowing us the opportunity to respond to your findings. If you have any questions or concerns, please feel free to contact me at (208) 381-9391.

Sincerely,

Jodi Brewster, BSN, RN, HACP
Director, Accreditation and Patient Relations

Enclosures

RECEIVED
FEB 15 2016

FACILITY STANDARDS

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

PRINTED: 02/02/2016
FORM APPROVED
OMB NO. 0938-0397

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2016
NAME OF PROVIDER OR SUPPLIER ST LUKE'S REHAB - ELKS SUB ACUTE REHAB UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 600 NORTH ROBBINS ROAD BOISE, ID 83702	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted from January 19, 2016 to January 21, 2016. The surveyors conducting the survey were: Linda Kelly, RN, Team Leader Juanita Stemen, MSN, RN, LNHA Survey definitions: DON/DNS = Director of Nursing DOP = Director of Pharmacy F = Fahrenheit FSS = Food Service Supervisor MDS = Minimum Data Set Assessment mg = milligrams RN = Registered Nurse w/c = Wheelchair	F 000	The following constitutes the facility's responses to the findings of the Department of Health and Welfare and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statements of deficiencies. RECEIVED FEB 15 2016 FACILITY STANDARDS	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure a call light was accessible for 1 of 8 residents (#9) during medication pass observations. The inaccessible call light created the potential for the resident's needs to be unmet if staff assistance was needed	F 246	In response to F-246 The Director of Nursing is ultimately responsible for ensuring residents have access to call lights and can receive staff assistance if needed or wanted. Residents who reside in this facility who utilize or may need to utilize a call light have the potential to be impacted by the identified finding <u>Plan of Correction:</u> -Resident #3 was provided his call light during survey. -Staff members caring for Resident #3 were immediately counseled regarding importance of ensuring call lights were within reach for all residents.	2/12/16

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

TITLE

(X8) DATE

Adrian Lopez

Senior Director

2/15/16

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 246	Continued From page 1 or wanted. Findings included: On 1/20/16 at 9:45 am, during a med pass observation with RN #3, Resident #9 was observed in his w/c with his call light in a wire basket on the wall above the head of his bed. LN #3 asked the resident where his call light was and the resident said he did not know. The LN found the call light in the wall basket and moved it next to the resident. On 1/20/16 at 9:50 am, RN #3 stated, "Even if he [Resident #9] was in the bed, he couldn't get to it [call light]."	F 246	<u>Plan of Correction continued:</u> -Unit staff educated via email and daily huddle to ensure residents' call lights within their reach. -Implementation of hourly rounding process to consist of clinical staff assessing each patients needs to include accessibility of call light. <u>QAPI Integration:</u> Nursing Supervisors to conduct random inspections to ensure residents have call lights accessible. These inspections will occur weekly for two weeks and then monthly for four months. Inspections to start on Monday February 15, 2016. Results of inspections to be reported monthly to the Quality Assurance and Performance Improvement Committee. Results of these inspections will also be shared with the Quality, Safety and Service Excellence Committee of the Board.		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and facility policy, it was determined the facility failed to prepare and distribute food under sanitary conditions to prevent potential foodborne illness. This failure had the potential to expose residents to foodborne illnesses from unsanitized thermometers, soiled hands, and soiled gloves. Findings include:	F 371	In response to tag F-371 The Food Service Manager is ultimately responsible for ensuring food is prepared and distributed in a manner to prevent potential foodborne illness including proper use of thermometers, gloves and hand hygiene.	2/16/16	

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F 371	<p>Continued From page 2</p> <p>1. On 1/18/16 at 9:10 am, Dishwasher#1 was observed attempting to pull a dish rack containing clean dishes from the dishwasher. Prior to applying clean gloves, the dishwasher dropped one of the gloves on the floor, which she then picked up, placed it on her hand, and then proceeded to pull the clean rack, containing clean dishes, onto the clean table.</p> <p>2. On 1/20/16 at 5:00 pm, Cook#2 was observed obtaining food holding temperatures (temperatures to prevent bacteria growth) prior to the evening meal. As Cook#2 began to check food temperatures, he removed the probe from its cover and without first sanitizing the thermometer, proceeded to test food temperatures. At 5:05 pm, Cook#2 was observed cleaning the thermometer by sliding it through his gloved fingers after removing it from the cover before testing the holding temperature on the gravy. At 5:15 pm, Cook #2 removed the cover from the thermometer and tested the mashed potato temperature without sanitizing the probe. Afterwards, prior to testing the temperature of the rice, Cook#2 cleaned the thermometer probe by sliding it through his gloved fingers, wiped it with his apron, and then tested the temperature of the rice.</p> <p>3. On 1/21/16 at 7:45 am, Cook#1 entered the dry storage area outside the kitchen and touched various stored items. Cook#1 also touched different areas on his face and nose and as he returned to the kitchen, immediately proceeded to pick up a clean pan and continue operations without washing his hands.</p> <p>On 1/21/16 at 8:00 am, the FSS stated he</p>	F 371	<p>Response to tag F-371 continued</p> <p>There were no individuals who had a negative impact based on identified deficiency. Residents who receive dietary services at this facility have the potential to be impacted.</p> <p><u>Plan of Correction:</u> -Individual follow-up and re-education provided to staff observed during survey. -Food and Nutrition Staff re-educated on proper sanitation measures for dietary services during staff meeting.</p> <p><u>QAPI Integration</u> Infection Prevention Practitioners to conduct random inspections of dietary services sanitation practices during various meal preparation times. Inspections to occur during one meal service daily for two weeks and then during three meal services weekly for four months. Results of inspections to be reported monthly to the Quality Assurance and Performance Improvement Committee. Results of these inspections will also be shared with the Quality, Safety and Service Excellence Committee of the Board.</p>	

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F 371	<p>Continued From page 3</p> <p>expected kitchen staff to clean the thermometer probe after removing the cover. The FSS stated that wiping the thermometer with gloved hands or aprons was not an acceptable practice and said the thermometer should have been cleaned in sanitizing solution or with an alcohol swab.</p> <p>The facility's "Food Safety Standards & Requirements," reviewed by the facility 3/13/15, documented thermometer stems "must be washed, rinsed and sanitized." Methods approved for cleaning the thermometers included sanitizing solution mixture, hot water (185° F), and alcohol swabs.</p> <p>According to the Centers for Disease Control and Prevention (http://www.cdc.gov/nczved/divisions/dfbmd/diseases/staphylococcal/#symptoms) foodborne illnesses, such as Staphylococcus aureus, a bacteria common to human skin and in noses, can induce symptoms such as, nausea, vomiting, diarrhea and stomach cramps.</p>	F 371	<p>In response to tag F-431</p>
F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the</p>	F 431	<p>The Director of Pharmacy is ultimately responsible for ensuring pharmacy labels include correct instructions for use to reduce the potential of harm to a resident by receiving an incorrect dose of medication.</p> <p><u>Plan of Correction:</u> - Patient specific, multi-dose medication containers will be labeled in the pharmacy to include resident name, medication name, and dose to be provided.</p> <p>2/25/16</p>



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F 431	Continued From page 4 appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure pharmacy labels included the correct medication dosage as ordered by the physician for 1 of 8 residents (#10) during medication pass observations. This failure created the potential for harm if Resident #10 received the wrong dosage of insulin. Findings included: On 1/21/16 at 8:50 am, RN #1 was observed as she drew up then administered Lantus insulin 25 units to Resident #10. The pharmacy label on the resident's multidose vial of Lantus insulin read, "one dose = 30 uni [units]."	F 431	<u>Plan of Correction continued:</u> -RNs will be educated via email and daily huddles to notify pharmacy that a new label is required for the particular medication. -Pharmacy to apply a new printed label, reflective of the new dose, to the patient specific, multi-dose medication containers. <u>QAPI Integration:</u> Nursing Supervisors to conduct random inspections to ensure all patient specific multiple dose medication containers are appropriately labeled. These inspection will occur weekly for two weeks and then monthly for four months. Results of inspections to be reported monthly to the Quality Assurance and Performance Improvement Committee. Results of these inspections will also be shared with the Quality, Safety and Service Excellence Committee of the Board.		

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F 431	Continued From page 5 On 1/21/16 at 9:05 am, when asked about the discrepancy between the Lantus 25 units administered and the pharmacy label instructions for 30 units, RN #1 said the Lantus order was changed the previous day. On 1/21/16 at 9:10 am, RN #4 reviewed the resident's orders and found a 1/19/16 order to decrease Lantus to 25 units daily. RN #4 also found the resident's original order, 30 units Lantus daily for diabetes mellitus, dated 1/12/16, and a 1/14/16 order that increased Lantus to 33 units daily. On 1/21/16 at 9:20 am, the DOP reviewed the resident's Lantus label. The DOP said medication labels would not be changed after multidose vials left the pharmacy.	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (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. (b) Preventing Spread of Infection	F 441	In response to tag F-441 The Director of Nursing is ultimately responsible for ensuring staff follow standard and facility infection control procedures, reducing the risk for cross-contamination during dressing changes. The resident involved in the observed care was assessed and no infection or negative impact was identified based on this finding. Residents who receive wound care services have the potential to be impacted by this identified finding. <u>Plan of Correction:</u> -Staff provided education on proper glove use and wound care practices via email and daily huddles.	2/12/16	

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NAME OF PROVIDER OR SUPPLIER ST LUKE'S REHAB - ELKS SUB ACUTE REHAB UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 600 NORTH ROBBINS ROAD BOISE, ID 83702		
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F 441	<p>Continued From page 6</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews, it was determined the facility failed to ensure staff followed standard- and facility infection control procedures for 1 (Resident#3) of 2 sampled residents with open wounds. This failure potentially exposed Resident#3 to cross-contamination from soiled gloves. Findings include:</p> <p>The MDS, dated 1/12/16, documented Resident#3 was admitted with a wound to the coccyx area. The resident's record included photos of the wound, dated 12/31/15, which was identified as "unstageable."</p> <p>On 1/21/16 at 10:55 am, RN #1 stated the wound was healing with granulation tissue noted. At</p>	F 441	<p><u>Plan of Correction Continued:</u></p> <p>-Staff completed in person wound care competency check off and re-inforcement of education related to proper glove use and infection prevention basics.</p> <p><u>QAPI integration:</u> Wound Care Nurse and/or Infection Prevention Practitioner to observe 30 random dressing changes monthly for four months, to ensure proper glove use and dressing change technique were utilized. Results of observations to be reported at Quality Assurance and Performance Improvement Committee. Results of these inspections will also be shared with the Quality, Safety and Service Excellence Committee of the Board.</p>	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/21/2016
NAME OF PROVIDER OR SUPPLIER ST LUKE'S REHAB - ELKS SUB ACUTE REHAB UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 600 NORTH ROBBINS ROAD BOISE, ID 83702		
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F 441	<p>Continued From page 7</p> <p>12:40 pm, RN#2 was observed providing wound care and a dressing change to the wound. After sanitizing his hands, RN#1 donned clean gloves and exposed the wound as the resident laid in bed, RN#2 then proceeded to a locked medicine cabinet and obtained the wound care supplies after unlocking the cabinet with a key from his pocket. RN#2 touched the resident, the bed, and the bedside table, wearing the same gloves, then proceeded to prepare supplies on a table. After opening the wound care supplies, RN#1, wearing the same gloves, removed the existing dressing, which was soiled with a moderate amount of serosanguinous drainage. After disposing of the dressing in a trash can, RN#2 continued providing the prescribed care to the resident's wound and applied a new dressing. RN#2 did not change gloves after touching the bed, the patient, the medicine cabinet door, the key, the bedside table, and the soiled dressing.</p> <p>On 1/21/16 at 1:00 pm, RN#2 stated he was required to clean his hands, verify patient identification, put gloves on, gather supplies, and proceed with care. When asked when he should change gloves, RN #2 stated gloves would be changed if they became soiled.</p> <p>On 1/21/16 at 3:30 pm, the DNS provided the facility's "Criterion Checklist/Sterile Dressing" procedure, dated 2/2012, and stated this checklist was used for all newly hired nurses during their clinical orientation on the second day of employment. The DNS stated newly hired nurses were not allowed to work with residents until they have completed the clinical orientation, which included a rotation with the wound care nurse. The Checklist outlined the procedure for sterile dressing changes and instructed staff, after</p>	F 441		

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F 441 Continued From page 8
removing a soiled dressing, to wash their hands
and don clean gloves.

F 441

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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2016
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NAME OF PROVIDER OR SUPPLIER ST LUKE'S REHAB - ELKS SUB ACUTE REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 600 NORTH ROBBINS ROAD BOISE, ID 83702
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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the state licensure survey conducted at the facility from January 19, 2016 to January 21, 2016. The surveyors conducting the survey were: Linda Kelly, RN, Team Leader Juanita Stemen, MSN, RN, LNFA Survey definitions: CDM = Certified Dietary Manager DM = Dietary Manager FSS = Food Service Supervisor RD = Registered Dietician	C 000		
C 268	02.107.01 Dietary Service 107. DIETARY SERVICE. 01. Dietary Supervision. A qualified food service supervisor shall be designated by the administrator to be in charge of the dietary department. This person shall: This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the DM failed to meet the State of Idaho qualifications to be the FSS. This lack of adequate training had the potential to negatively affect all residents in the facility. Findings included: On 1/19/16, the facility provided a list of key facility personnel, which listed the DM as the FSS, and included the DM's "ServSafe" Certification. On 1/20/16 at 3:40 pm, the Administrator said the DM was not a CDM, but there were RDs on staff	C 268	In response to tag C-268 The Sr. Director of Rehab Hospital is ultimately responsible for ensuring the Dietary Manager meets the required qualifications to serve as a Food Services Supervisor. Plan of Correction: -Dietary Manager enrolled in a Certified Dietary Manger program. -Food Services Supervisory responsibilities transferred to a Certified Dietary Manager.	2/7/16

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FACILITY STANDARDS

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

Senior Director

2/15/16

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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/21/2016
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C 268	Continued From page 1 who managed diets. On 1/21/16 at 3:30 pm, the Administrator said the DM was currently enrolled in a CDM program and would complete the program in February 2016.	C 268		