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April 23, 2012

Joseph Caroselli, Administrator
Idaho Elks Rehabilitation Hospital
PO Box 1100
Boise, ID 83702

Provider #133025

Dear Mr. Caroselli:

On **April 3, 2012**, a complaint survey was conducted at Idaho Elks Rehabilitation Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005321

Allegation #1: Facility staff did not appropriately allow patients to manage their diabetes independently.

Finding #1: An unannounced survey was conducted from 4/02/12 through 4/03/12. Staff and patients were observed and interviewed. Medical records, policies and procedures, and complaints were reviewed.

Eight medical records of patients with the co-morbidity of diabetes were reviewed. Three were closed records and five were open records. Six patients were observed receiving direct care. Five patients were receiving wound care and one patient was receiving Hyperbaric Oxygen Therapy (HBO). All patients observed had diabetes.

One record reviewed documented a 68 year old female who started receiving wound care for a diabetic foot ulcer on 2/25/11. On her first visit, the nursing note documented the patient reported feeling like her blood glucose was low. Nursing staff checked her blood glucose and then gave her apple juice and a candy bar. The patient refused to have nursing staff recheck her blood glucose after the snack was provided.

On 4/03/12, one patient was observed having a blood glucose level check following HBO treatment. After the Hyperbaric Certified Technician (HBCT) cleaned the patient's finger, the patient asked to use the lancet to obtain a blood sample on herself. The HBCT gave the patient the lancet, then the patient obtained the blood sample while the HBCT held the glucometer test strip in gloved hands for the patient to apply her blood to the test strip.

Five patients were interviewed regarding the treatment of diabetes when in the facility. All five patients interviewed stated they did not have concerns related to how the facility managed their diabetes. All interviewed patients reported the facility had not had to check their blood glucose. The five patients reported they managed their diabetes at home and that facility staff would ask them about their blood glucose range.

One registered nurse (RN) was interviewed on 4/03/12 regarding diabetic care in the facility. She stated blood glucose levels were checked when a patient did not monitor them at home or if the patient reported a problem with their blood glucose levels while receiving care. The RN stated she would use the facility's glucometer, even if the patient had their own with them.

It could not be determined the facility did not appropriately allow patients to manage their diabetes independently.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Facility staff failed to recognize an insulin emergency.

Finding #2: An unannounced survey was conducted from 4/02/12 through 4/03/12. Staff and patients were observed and interviewed. Medical records, policies and procedures, and complaints were reviewed.

Eight medical records of patients with the co-morbidity of diabetes were reviewed. Three were closed records and five were open records. Six patients were observed receiving direct care. Five patients were receiving wound care and one patient was receiving Hyperbaric Oxygen Therapy (HBO). All patients observed had diabetes.

One record reviewed documented a 68 year old female who started receiving wound care for a diabetic foot ulcer on 2/25/11. On her first visit, the nursing note documented the patient reported feeling like her blood glucose was low. Nursing staff checked her blood glucose, which was 58 mg/dL. Per facility policy, a blood glucose less than 50 mg/dL was considered a critically low value. Therefore, the patient's blood glucose level was not an insulin emergency and the nurse gave her apple juice and a candy bar. The patient refused to have nursing staff recheck her

blood glucose after the snack was provided.

Five patients were interviewed regarding the treatment of diabetes when in the facility. All five patients interviewed stated they did not have concerns related to how the facility managed their diabetes. All interviewed patients reported the facility had not had to check their blood glucose. The five patients reported they managed their diabetes at home and that facility staff would ask them about their blood glucose range.

One Site Manager was interviewed on 4/02/12. He stated diabetic patients receiving HBO treatments had to have their blood glucose levels checked pre- and post-treatment as the pressure changes related to HBO could cause faster metabolization of glucose. He said staff were trained to monitor for signs and symptoms of potential insulin emergencies.

A Hyperbaric Certified Technician was interviewed on 4/03/12. She stated she not only checked diabetic patients' blood glucose levels pre- and post-treatment, but she also monitored patients for potential insulin emergencies.

It could not be determined facility staff failed to recognize an insulin emergency.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Facility staff failed to follow universal precautions.

Finding #3: An unannounced survey was conducted from 4/02/12 through 4/03/12. Staff and patients were observed and interviewed. Medical records, policies and procedures, and complaints were reviewed.

Six patients were observed receiving direct care from facility staff. Five patients were receiving wound care and one patient was receiving Hyperbaric Oxygen Therapy (HBO). All patients observed had diabetes.

Five patients receiving wound care were observed and interviewed. All five patients stated they observed staff performing hand hygiene and wearing gloves for procedures. Staff were observed performing hand hygiene before and after patient contact, before donning gloves and after removing gloves. Staff were also observed to wear gloves as appropriate during procedures.

One Hyperbaric Certified Technician (HBCT) was observed on 4/03/12 performing a blood glucose level check using a glucometer on a diabetic patient post-HBO treatment. The HBCT washed her hands, donned gloves, cleaned the patient's finger with an alcohol wipe, then washed her hands after removing the gloves. The HBCT was not observed to clean the glucometer after

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checking the patient's blood glucose level.

The HBCT was interviewed following the above observation. She stated she normally immediately cleaned the glucometer with a germicidal cloth. However, she was unable to leave her station to get the germicidal cloths immediately due to patient monitoring responsibilities. She stated once her immediate monitoring responsibilities were completed she would clean the glucometer and put it away appropriately.

It could not be determined facility staff failed to follow universal precautions.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/srm