



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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April 30, 2013

Julie J. Johansen, Administrator
Prestige Care & Rehabilitation - The Orchards
1014 Burrell Avenue
Lewiston, ID 83501-5589

Provider #: 135103

Dear Ms. Johansen:

On **April 9, 2013**, a Complaint Investigation survey was conducted at Prestige Care & Rehabilitation - The Orchards. Marcia Key, R.N. and Nina Sanderson, L.S.W. conducted the complaint investigation.

The complaint team interviewed the following staff members: Administrator, Director of Nursing (DoN), three Resident Care Managers (RCMs), Business Office Manager (BOM), three Registered Nurses (RNs), 12 CNAs (Certified Nurse Aides), representing day and evening shifts and one Occupational Therapist (OT) whose first name was identified in the complaint.

The complaint team reviewed the records of the two residents identified in the complaint. A Recertification and State Licensure survey was conducted at the facility, February 25 through March 1, 2013. Twenty-five residents were reviewed at that time, with no deficient practices identified related to informed consent or delegation of medication.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005959

ALLEGATION #1:

The complainant stated an identified resident was asked to sign a medication consent form

without adequate knowledge of the content of the form.

FINDINGS:

The BOM stated she was routinely assigned to present the identified resident with forms to sign, as she had the best rapport with the identified resident for this activity. The BOM stated she presented the identified resident with a consent form for a medication ordered by the physician, and the resident willingly signed the form.

The Administrator stated residents were consistently presented information to make informed choices about their care, and the facility respected a resident's right to refuse medications.

The DoN stated residents were consistently presented information to make informed choices about their care. The DoN stated the identified resident did refuse her medications at times, and there had been interdisciplinary team discussions to brainstorm ways to increase the resident's acceptance of medications.

The RCMs stated the identified resident had consented to the use of the medication but refused to take her medications at times.

One RN stated the identified resident would accept medications at times and refuse them at other times. The RN stated refusals were documented in the identified resident's medical record.

The identified resident's record included a consent form for a medication signed by the resident. The identified resident's record documented occasions that medication, along with other medications, had been offered to the resident but the resident refused to take the medications.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated a licensed nurse, identified by first name only delegated medication administration to an unidentified CNA and an OT (Occupational Therapist,) identified by first name only. This involved a resident, identified by last name only.

The complainant stated this was common practice in the facility amongst other nurses as well.

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FINDINGS:

The OT stated she had never been asked to administer medications to residents. She had not heard or seen any licensed nurses attempt to have unlicensed nursing staff give medications to residents. The OT also stated no therapy staff had reported this practice to her.

The 12 CNAs interviewed stated they had never been asked by any nurse to administer medications to residents. They stated they would report such a request immediately to their supervisor. They also stated they had not witnessed this practice.

The four RNs interviewed stated they had never asked a non-licensed person to administer medications. They all denied having witnessed or having knowledge of other licensed nurses doing this in the facility. They stated they would report the practice immediately if they were aware of it.

The identified resident's record documented consistent refusals of only one medication, and that medication was discontinued by the physician due to those refusals.

The DoN stated the identified nurse's assigned duties would not have included the administration of medication to residents. The identified nurse was not available for interview.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser". The signature is written in a cursive, slightly slanted style.

LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LKK/dmj