



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7012 1010 0002 0836 1543

July 11, 2014

Joseph P. Caroselli, Administrator
Idaho Elks Rehabilitation Hospital & SubAcute Rehabilitation Unit
600 North Robbins Road (83702-4539,) PO Box 1100
Boise, ID 83701-1100

Provider #: 135114

Dear Mr. Caroselli:

On **June 27, 2014**, a Complaint Investigation survey was conducted at Idaho Elks Rehabilitation Hospital & SubAcute 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 an isolated deficiency that constitutes actual 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 3). **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

Joseph P. Caroselli, Administrator

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CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 24, 2014**. Failure to submit an acceptable PoC by **July 24, 2014**, may result in the imposition of civil monetary penalties by **August 13, 2014**.

The components of a Plan of Correction, as required by CMS include:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title who will do the monitoring.
 - * It is important that the individual doing the monitoring have the appropriate experience and qualifications for the task.
 - * The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3.
 - * A plan for "random" audits will not be accepted.
 - * Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- 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.

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- 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 **August 1, 2014 (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 **August 1, 2014**. A change in the seriousness of the deficiencies on **August 1, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 1, 2014** includes the following:

Denial of payment for new admissions effective **September 27, 2014**. [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 **December 27, 2014**, 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, they will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626; 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 **June 27, 2014** and continue until substantial

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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)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)

[2001-10 IDR Request Form](#)

This request must be received by **July 24, 2014**. If your request for informal dispute resolution is received after **July 24, 2014**, 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 Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,



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

LKK/dmj
Enclosures

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

PRINTED: 07/28/2014
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 C 06/27/2014
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NAME OF PROVIDER OR SUPPLIER ID ELKS REHAB HOSP SUBACUTE REHAB UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 600 NORTH ROBBINS ROAD, 83702-4539 BOISE, ID 83701
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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 complaint investigation conducted at your facility.</p> <p>The surveyors conducting the survey were: Susan Gollobit RN, Team Leader Lorraine Hutton, RN</p> <p>The survey team entered the facility on Thursday, June 26, 2014 and exited the facility on Friday, June 27, 2014.</p> <p>Survey Definitions:</p> <p>ADL = Activities of Daily Living CNA = Certified Nurse Aide DON = Director of Nursing MAR = Medication Administration Record MDS = Minimum Data Set assessment PBA = Physical Assessment Baseline PCN = Patient Care Note POPN = Physicians Orders & Progress Notes RN= Registered Nurse</p>	F 000	<p><u>GENERAL DISCLAIMER</u></p> <p>Preparation and Execution of this response and Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law. This Plan of Correction shall serve as our credible allegation of compliance.</p>	
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p>	F 225	<p>RECEIVED AUG 01 2014</p> <p>FACILITY STANDARDS</p> <p>1) On 6/5/14 Resident #1 was assessed by the Attending Physician, who was aware of both the 6/2/14 & 6/4/14 incidents. An investigation of the 6/4/14 incident was initiated on 6/5/14. On 6/27/14 the Director of Nursing and Interim Compliance/ Risk Manager initiated a thorough investigation of both the 6/2/14 and 6/4/14 incidents which included a root cause analysis. An incident report for 6/2/14 was completed by the RN present at the time the event occurred. Late entry notations were made in Resident #1's record concerning the 6/4/14 incident and an incident report was completed. The facility has provided a report of the incident to the Bureau of Facility Standards related to this incident. The staff involved in the incident/transfer received a 1:1 re-education regarding transfer techniques, use of foot rests, and reporting of injuries.</p>	8/01/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Joseph P. Curwell</i>	TITLE <i>NH Administrator</i>	(X6) DATE 8/1/14
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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 225	Continued From page 1 The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of incident and accident reports, record review, facility policy review, and staff interview, the facility failed to thoroughly investigate incidents that either caused or had the potential to result in resident injury. In addition, the facility failed to report an incident to the Bureau of Facility Standards (BFS) that likely resulted in a resident's re-fracturing a leg she had recent surgery on. This affected 1 of 3 residents reviewed (#1) and placed the resident at risk for further injury/possible neglect. Findings include:	F 225	2) Director of Nursing and RN Staff completed quality rounds and resident care interviews the week of 7/17/14-7/23/14. Assessment findings demonstrated that there were no unknown or unreported injuries. The Director of Nursing and Administrator reviewed the incident reports for the prior 30 days to ensure that incidents have been thoroughly investigated and that there were no events that required external reporting. 3) In-service education was provided by the Director of Nursing & Administration to Nursing Staff on 7/22/14, regarding Abuse Prevention and Reporting along with Incident Reporting, Change of Condition Documentation. The in-service included the requirement that incidents are to be reported to the administrator or designated representative and to other officials in accordance with State law (including to the State survey and certification agency). All other staff will receive training on new Abuse Policy by 7/31/14. 4) Starting on 7/17/14, the RN Supervisor or Designee will conduct Incident/Change of Condition Audits 5x /week x 1 month, then bi-weekly x 4 weeks, and weekly x 3 months. Outcome of the Change of Condition & Incident Audits will be reported to Director of Nursing & Administration for immediate correction. Compliance rates and trends will be reviewed at the Sub-acute Rehabilitation Quality Assurance Performance Improvement Committee Meetings monthly for 3 months, and then quarterly for further action as indicated. 5) Corrective action will be completed 8/01/14.		

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F 225	<p>Continued From page 2</p> <p>Resident #1 was admitted to the facility on 5/30/14 following a ORIF (open reduction internal fixation) for a left femoral neck fracture on 5/26/14. The resident's admission diagnoses included Parkinson's disease, arthritis, anxiety, dementia, history of transient ischemic attacks (TIA/stroke) and diabetes mellitus.</p> <p>Resident #1's Physician's Admission Orders dated 5/30/14 documented the resident was on, "WBAT [weight bearing as tolerated] LLE [left lower extremity] with posterior precautions." The admission orders also listed: * Follow up with (Orthopedic Surgeon) in 2 weeks, * Physical Therapy and Occupational Therapy to evaluate and treat for safety balance, strength, ADLs, and restorative function.</p> <p>The 5/31/14 A.M. Physical Baseline Assessment (PBA) for nursing documented the resident was anxious and confused, unable to follow one part commands, had impaired strength or sensation, and impaired mobility limited by pain, balance, endurance, and an unsteady gait. A 6/2/14 A.M. PBA documented the resident was impulsive and lacked safety awareness.</p> <p>During review of Resident #1's clinical/medical record, dated 5/30/14 through 6/19/14, it was determined Resident #1 experienced two separate incidents that could either indicate the surgical leg was at risk of having been re-injured or that could have directly resulted in a re-injury of her left surgical leg. The first incident occurred on 6/2/14 and the second on 6/4/14. The two incidents occurred during transfers to/from the wheelchair and transport via wheelchair to the bathroom.</p>	F 225		

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F 225	<p>Continued From page 3</p> <p>a. 6/2/14 Incident A PCN dated 6/2/14 at 5:00 PM documented, "[The resident's] spouse arrived to see [the resident] after receiving a phone call from [the resident] that she had, 'hurt her leg again.' Reviewed with spouse that when toileting earlier this date, the staff did hear a 'popping' sound in the [left] hip. I was notified and v/s [vita signs] were taken... hip was visually assessed and [was without signs or symptoms] of baseline change. [The resident] was medicated for mild pain with good results."</p> <p>A POPN dated 6/4/14 at 12:35 PM documented, "during a transfer on 6/2 nursing heard a popping sound, but [there] was not in visible distress and denied pain. [Resident] has c/o [complained of pain] intermittently since and complaining of "tightness" in left thigh. Pleas ed advise." This entry was signed by an RN. At 12:30 PM the RN added, "Pt [patient] perseverates at times and requesting an x-ray. Notified [Resident's physician]." On 6/4/14, a 1:00 PM POPN note documented the resident was scheduled for an x-ray on 6/4/14 at 1:15 PM.</p> <p>The resident's medical records, including the POPNs, PCNs, House Rounds notes, and PABs for 6/2/14 through 6/9/14 documented the 6/2/14 incident was followed closely by nursing and medical staff, the resident was appropriately assessed related to the incident and an x-ray was taken of the resident's surgical (left) hip on 6/4/14 at 1:15 PM. House Rounds notes for 6/5/14 and 6/6/14 documented the X-rays were reviewed by multiple physicians who determined that no re-injury had occurred, surgery was not necessary, and the resident was stable for</p>	F 225		

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F 225	<p>Continued From page 4</p> <p>rehabilitation. However, no incident report was found for the 6/2/14 "popping" heard during a transfer of the resident.</p> <p>During an interview on 6/26/14 at 4:20 PM, the MDS nurse stated an incident report should have been initiated for the 6/2/14 incident by the staff who heard the popping sound as they transferred Resident #1 to the toilet. The MDS Coordinator later returned stating he could not locate an incident report.</p> <p>On 6/27/14 at 9:45 AM the DON was interviewed. The DON confirmed an incident report had not been initiated or completed.</p> <p>b. 6/4/14 Incident On a 6/5/14 Complaint Event Summary, the facility's Licensed Social Worker (LSW) documented, "I received a call from [a family member] who said he was very disappointed in the care his mother is receiving from nursing. Last night (6/4/14) at approximately 9:15 pm [the family member] witnessed two CNAs take his mother to the bathroom in her w/c [wheelchair] without leg rests. The [resident] was yelling out in pain. On the way back, the [resident's] leg was dragging and got stuck under the wheelchair. The [resident] was calling out in extreme pain..."</p> <p>The resident's medical record, dated 6/5/14 through 6/19/14, documented Resident #1 experienced increased pain, required medication for anxiety, and experienced a decline in her functional status related to issues with the left hip following the 6/4/14 incident. In addition, twelve days following this incident, a second fracture of the surgical hip (left hip) was identified during a routine follow-up visit with the resident's</p>	F 225		
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F 225	<p>Continued From page 5</p> <p>orthopedic surgeon and the resident underwent a second surgical repair of her left hip. Refer to F 309 for details.</p> <p>In addition, there was no nursing documentation, physician documentation, or physical assessment on the PCNs, POPNs, or PBAs for 6/4/14 and 6/5/14 that directly addressed the reported incident except a PCN written by the LSW, dated 6/5/14 at 12:43 PM, which documented the CEO, program director, and DON were notified of the family member's grievance.</p> <p>On 6/26/14 at 4:20 PM the MDS Coordinator and Staff #3 were interviewed regarding the 6/4/14 incident where staff failed to use foot rests when transporting Resident #1 to/from the bathroom. Staff #3 was identified by the acting administrator as the person who received incident and accident reports and kept them on file. Staff #3, when asked where the summary of the incident was, and asked if the incident been reported to BFS, deferred to the DON who would return to work in the morning. Note: During the entrance on 6/26/14 at 1:15 PM, the Administrator stated the DON was on bereavement leave.</p> <p>On 6/27/14 at 9:45 AM the DON was interviewed. She provided additional components of the investigation including written statements by the involved CNAs, dated 6/9/14 and 6/10/14. When asked if the RN charge nurse or the RN assigned to the resident on the evening of 6/4/14, had been interviewed the DON stated, "No." When asked if there was a summary or a root/cause/analysis of the event the DON stated, "No," the report was not completed yet. The DON also stated the BFS had not been notified when the facility determined there was a re-fracture of the surgical leg which</p>	F 225			

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F 225	Continued From page 6 would require surgical repair. The investigation report, initiated on 6/5/14, failed to: * Document that the CNAs involved in the incident were interviewed/counseled until 6/9/10 and 6/10/14, 5 - 5 days after the incident. * Document interviews with the charge nurse and/or attending nurse on duty the evening of 6/4/14. * Provide a summary of the incident and investigation or root/cause/analysis of the incident. * Document that the BFS was notified of the incident and/or failed to notify BFS that the resident had re-fractured hip her surgical hip and would require a second surgical repair. On 6/27/14 at 1:30 PM, the acting administrator, DON, and Care Manager were informed of the failure to complete the investigation, counsel/re-train the CNAs in a timely manner, and report the re-fracture to the BFS. No additional information was provided.	F 225			
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the facility's policies to prevent abuse, it was	F 226	F226 1) Effective 7/18/14, Administration reviewed and revised the Facility's Patient Abuse Prevention and Reporting Policy to include additional elements. The policy now includes: the protection of residents during abuse investigations; the required reporting to the Bureau of Facility Standards of alleged abuse and neglect and submission of the completed report; and identification of areas that need to be reported and investigated.	8/01/14	

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F 226	<p>Continued From page 7</p> <p>determined the policies did not ensure:</p> <ul style="list-style-type: none"> *The protection of residents during abuse investigations, *The immediate reporting to the Bureau of Facility Standards (BFS) of all alleged violations of abuse and neglect and submission of the completed report, and *Identify all areas that needed to be reported and investigated. <p>This had the potential to affect any resident in the facility that may be subject to potential abuse or neglect including 1 of 3 residents (#1) reviewed for accidents and injuries. The lack of a comprehensive abuse policy created the potential for residents to not be protected while an abuse investigation was in process. Findings include:</p> <p>1. Page 3 of 4 on the facility's undated, "Patient Abuse Prevention and Reporting," policy documented, "PROTECTION: A. All possible precautions will be taken to safeguard the alleged victim's rights during the investigation, B. Patient care assignments will be adjusted to protect the rights of patient and the accused employee..."</p> <p>Page 5 of 5 of BFS's Informational Letter #2014-04, Resident Abuse Reporting in SNF/NFs requires that an "... accused staff person must be suspended until the investigation is completed, in order to protect residents from further abuse."</p> <p>2. Page 4 of 4 on the facility's undated "Patient Abuse Prevention and Reporting," policy documented the Compliance Officer will, "Assure the reporting of results to the proper authorities when reasonable proof exists within 24 hours." The policy then listed the telephone numbers for BFS as well as Adult Protective Services, Child Protective Services, and the local Police</p>	F 226	<p>2) The revised Abuse Policy was reviewed by the Interim Risk Manager on 7/21/14, and finalized 7/23/14. The revised policy was confirmed to include the required elements in accordance with the Bureau of Facility Standards Information letter #2014-04. The updated Abuse Prevention and Reporting policy has been added to the facility policy manual.</p> <p>3) In-service education was provided on 7/22/14 to Nursing Staff by the Director of Nursing/Administration regarding the revised Abuse Prevention & Reporting Policy. Additional staff training will be provided to the remaining staff by 7/31/14. The revised Abuse Policy was reviewed by the Sub-acute Rehabilitation Unit Quality Assurance Performance Improvement Committee on 7/22/14, and signed off by the Medical Director on 7/23/14.</p> <p>4) Starting on 7/17/14, the Director of Nursing or their designee will audit incidents 5x/ week x 4 weeks, bi-weekly x 4 weeks, and weekly x 3 months to ensure adherence with the revised Policy. Any non-compliance will be reported promptly to the Director of Nursing/Administration and will be immediately addressed. Results of the audits will be reviewed and discussed at the monthly Sub-acute Rehabilitation Unit Quality Assurance Performance Improvement Committee, x3 months then quarterly thereafter for review and further recommendation.</p> <p>5) Date of Compliance 8/01/14.</p>		

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F 226	<p>Continued From page 8 Department.</p> <p>Page 3 of 5 of Informational Letter #2014-04, Resident Abuse Reporting in SNF/NFs states, "All allegations [of abuse/neglect] must be immediately reported to the facility's administrator and to the Department's hotline... Immediately means as soon as reasonably possible, and no later than 24 hours from the discovery of the incident. FAX the completed investigation to the survey agency within (5) working days."</p> <p>3. The facility's "Patient Abuse Prevention and Reporting," policy failed to list all situations that must be reported and investigated including, but not limited to:</p> <ul style="list-style-type: none"> * "Staff mistakes that result in the resident's need for hospitalization, treatment in a hospital emergency room, fractured bones, IV treatment, dialysis, or death. Some examples of staff mistakes include failure to adhere to a care plan, failure to notify the physician timely of a significant change, failure to implement nursing standards, * Accidental death of a resident from any cause, and * Any resident death, from any cause, that occurs while the resident is physically restrained." <p>On 6/27/14 at 9:45 a.m., the facility's abuse policy prevention and investigation policy and procedures were discussed with the DON. The DON was asked how residents were protected during abuse investigations. The DON stated that staff would be re-educated regarding the issues and maybe reassigned depending on the circumstances. When asked if Resident #1's fractured leg (Please refer to F 309 for citation) was reported to the BFS, the DON stated, "No."</p>	F 226		

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F 226	Continued From page 9 When asked if she was aware of the BFS informational letter on reporting resident abuse reporting, the DON stated she was not familiar with the letter. The Acting Administrator, DON, and Program Manager were notified of these findings on 6/27/14 at 1:15 PM.	F 226			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of incident and accident reports, and staff interview, the facility failed to: * Properly transfer a resident * Assess the resident after the improper transfer * Notify the attending or the orthopedic physician, in a timely manner, after the resident was improperly transferred and experienced increased pain and decreased functional status. This was true for 1 of 3 residents (#1) sampled for injury accidents. Resident #1, was harmed when she did not receive an x-ray of a fractured leg until 12 days after an improper transfer and documented increased pain and decreased functional status. That x-ray taken 12 days after	F 309 F 309	1) Resident #1 was physically assessed by the Attending Physician on 6/5/14 after being told of the 6/4/14 patient incident by the patient's son. On 6/5/14, following his assessment of the patient, the Attending Physician requested that the DON visit the family to address the family's complaint concerning the 6/4/14 patient occurrence. The DON interviewed the family and patient on 6/5/14. The DON followed up the next two days and documented her findings in the record. Staff involved received 1:1 transfer/transport training from Physical Therapy with return demonstration. The SubAcute Rehabilitation Unit (SRU) management team did a root cause analysis on 7/22/14 and another with the Medical Director on 7/30/2014 as to why this patient occurrence was not documented in the patient's chart, there was inadequate investigation and lack of reporting to Bureau of Facility Standards.	8/01/14	

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F 309	<p>Continued From page 10</p> <p>the transfer revealed a re-fracture of the left leg that required surgical intervention. This was true of 1 of 3 residents reviewed (#1). Findings include:</p> <p>Resident #1 was admitted to the facility on 5/30/14 following an ORIF (open reduction internal fixation) for a left femoral neck fracture on 5/26/14. The resident's admission diagnoses included Parkinson's, arthritis, osteoporosis, anxiety, dementia, history of transient ischemic attacks (TIA/stroke) and diabetes mellitus.</p> <p>Resident #1's Physician's Admission Orders dated 5/30/14 documented the resident was on, "WBAT [weight bearing as tolerated] LLE [left lower extremity] with posterior precautions." The admission orders also listed:</p> <ul style="list-style-type: none"> * Follow up with (Orthopedic Surgeon) in 2 weeks * Physical Therapy and Occupational Therapy to evaluate and treat for safety balance, strength, ADLs, and restorative function * Tylenol 1000 mg (milligrams) orally every eight hours * Oxycodone 5 - 10 mg po (by mouth) every 4 hours for severe pain * Tramadol 50 - 100 mg po every 6 hours prn (as needed) for pain * Lorazepam 0.25 mg po TID (three times per day) prn agitation/anxiety <p>The 5/31/14 A.M. Physical Baseline Assessment (PBA) for nursing documented the resident was anxious and confused, unable to follow one part commands, had impaired strength or sensation, and impaired mobility limited by pain, balance, endurance, and an unsteady gait. A 6/2/14 A.M. PBA documented the resident was impulsive and lacked safety awareness.</p>	F 309	<p>1) Cont.</p> <p>The SRU management team concluded that nursing failed to report the incident due the fact the CNA did not recognize this as an adverse event and had an incomplete understanding of what types of events need to be reported. RN staff failed to document the incident and/or notify the physician because the CNA failed to report up to the RN. On 6/5/14, the family complained to the LSW who started an incident report. The RN failed to add to this report because she was not notified of any adverse event. Risk Management failed to conduct a thorough investigation. Administration did not report the patient's return to the acute on 6/16/14 to BFS. The root cause analysis also revealed a lack of physician documentation related to the incident. The administrator spoke with the Attending Physician on 7/28/14 concerning re-training physicians on documenting patient events in the medical record so a better plan of care can be developed to address patient needs. Hospital staff was educated about incidents, reporting, and abuse. Attending and Internal Medicine Physicians were educated about incident reporting and, the need to document events in the medical record, including these facts: what occurred, patient's response to the occurrence, actions taken, and patient outcome. Resident #1 was assessed upon readmission on 6/24/14 and an appropriate plan of care was developed to ensure the</p>		

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F 309	Continued From page 11 Resident #1's 5 day Medicare Assessment, dated 6/6/14, documented: memory problem; severely impaired decision making skills, inattention, disorganized thinking; extensive assistance of two people required for bed mobility, transfers, toilet use, personal hygiene, unsteady balance during transitions requiring staff assistance, occasional incontinence of urine, continent of bowel, experienced severe pain. Review of Resident #1's clinical/medical record, dated 5/30/14 through 6/19/14, determined that Resident #1 experienced two separate occurrences of potential left hip injury between 6/2/14 evening shift and 6/4/14 at 9:15 PM. The two incidents occurred during transfers to/from the wheelchair and/or transport via wheelchair to the bathroom. a. 6/2/14 incident. Review of Resident #1's medical record for 6/2/14 through 6/5/14 revealed the following: * Patient Care Notes (PCNs) - 6/2/14 at 5:00 PM, documented, "[Resident's family member] arrived to see [resident] after receiving a phone call from the [resident] that she had "hurt her leg again." Reviewed with staff that when toileting earlier this date, the staff did hear a "popping" sound in the [left] hip. I was notified and v/s [vital signs] were taken [within normal limits], hip was visually assessed [without signs or symptoms] of baseline change. [Resident] was medicated for mild pain with good results.... [Resident] was found in [Assisted Dining Room] enjoying her meal and without obvious signs of distress..." This entry was made by an RN. The incident was not addressed again in the resident's medical record, including PCNs, Physician's Orders and Progress Notes (POPNS), Hospital Rounds notes, or	F 309	1) Cont. necessary care and services are provided to attain or maintain the highest practicable, physical, mental, and psychosocial well-being. The current assessment includes the resident's current transfer status needs. Resident #1 has been making functional gains, with effective pain management and progress towards goals. 2) Director of Nursing and RN Staff conducted quality rounds and resident care interviews the week of 7/17/14-7/23/14. Patients were assessed for change of condition, pain management, and injuries related to unreported incidents of which none were identified. On 7/30/14, current in-house patients were physically re-assessed by an RN and interviewed. No changes of condition were noted that had not been properly addressed through a plan of care modification. Quality rounds will be conducted by RN/Designee weekly for 3 months. 3) The Medical Director provided written education to the attending medical staff and the consulting internal medicine staff on 7/31/14 directing doctors to document the facts regarding a patient occurrence in a patient's medical record; these facts include what occurred, patient response to the occurrence, actions taken, and patient outcome. On 7/22/14, a new "Report up Report" Form and work flow was initiated in the nursing department.		

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F 309	Continued From page 12 Physical Assessment Baseline Notes until 6/4/14. *POPN - 6/4/14 at 12:35 PM, documented, "During a transfer on 6/2 nursing heard a popping sound, but [she] was not in visible distress and denied pain. [Resident #1] has c/o [complained of pain] intermittently since and complaining of "tightness" in left thigh. Pleased advise." This entry was signed by an RN. At 12:40 PM, the RN added, "Pt perseverates at times and requesting an x-ray. Notified [Resident's assigned Physician]." A 1:00 PM POPN documented the resident was scheduled for an x-ray on 6/4/14 at 1:15 PM. *POPN - 6/4/14 at 5:23 PM, the same RN who made the 12:35 PM entry on the POPN documented the x-ray results were paged to [the resident's orthopedic surgeon] and the films were faxed to the local hospital. *Hospital Rounds - 6/5/14 at 12:03 PM completed by the resident's assigned physician, documented, "X-rays done yesterday revealed lucency [dark areas indicating decreased opaqueness], which were reviewed by [Orthopedic physician on call]... who reviewed them with [A second orthopedic physician]... Both did not think there was a fracture on that side [Left]. They felt that this [long bone adjacent to the femoral component] was likely settling. They recommended touch down weight bearing, and that would give them a chance to see if it would heal and then follow up with [Resident's Orthopedic Surgeon]... We will put the precautions in place..." *POPN - 6/5/14, a physician's order, noted at 12:23 PM, documented the resident was to be on,	F 309	3) Cont. Nursing staff was trained on 7/22/14 to use the Report up Report to inform their supervisor of care or workflow concerns. The purpose of the new report is to enhance the reporting process and to get timely information to supervisors so they may determine if a more complete investigation of an event is required. As of 7/23/14, an Interdisciplinary "Huddle Team" was initiated and will meet 5x/week to review incidents, change of condition, admission, discharges, and "Report up Reports". Based on the root cause analysis there was retraining of staff by the Director of Nursing & Departmental Managers on 7/22/14 regarding : how to properly transfer/ transport patients, equipment use, report up procedures and report form, incident report completion, documenting, and physician notification. The Pain flowsheet was modified by the Director of Nursing to include an assessment of medication effectiveness. These processes will help assure that future incidents are identified , fully investigated, and reported as required. The Interim Risk Manager provided a verbal report to the BFS hotline on 7/27/14. The Interim Risk Manager faxed the investigation summary report to BFS on 7/31/14.		

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F 309	<p>Continued From page 13</p> <p>"(TDWB) Touch Down Weight Bearing on the left side and for staff to please arrange for follow-up with (Resident's Orthopedic Surgeon)." The person noting the order at 12:51 PM documented, "[Resident] has appt [appointment] already scheduled for 6/16 at 1100." No other contacts with the orthopedic surgeons office were documented.</p> <p>b. 6/4/14 incident *Complaint Event Summary - 6/5/14, the facility's Licensed Social Worker (LSW) documented, "I received a call from [Resident #1's family member] who said he was very disappointed in the care the resident is receiving from nursing. Last night (6/4/14 at approximately 9:15 pm) [the family member] witnessed two CNAs take [the resident] to the bathroom in her w/c [wheelchair] without leg rests. The [resident] was yelling out in pain. On the way back, the [resident's] leg was dragging and got stuck under the wheelchair. The [resident] was calling out in extreme pain..." The 6/5/14 event summary did not document notification of the resident's physician or any physician.</p> <p>There was no nursing documentation, physician documentation, or physical assessment on the PCNs, POPNs, or PBAs for 6/4/14 and 6/5/14 that directly addressed the incident on the evening of 6/4/14, until the LSW noted on a PCN, dated 6/5/14 at 12:43 PM, that, "the CEO, program director, and DON were notified of the...grievance," and the family member was given a complaint form to complete.</p> <p>*PCN - 6/5/14 at 1:57 AM documented the resident was very anxious at 8:15 PM, complained of, "slight chest pain which was</p>	F 309	<p>4) Change of Condition/Incident chart audits, and started on 7/17/14 and will be conducted by the RN Supervisors and/or Designee 5x/week for 1 month, bi-weekly x 4 weeks, and then weekly x 3 months. Quality rounds will be conducted weekly by the DON or Designee, x 8 weeks then bi-monthly thereafter. This will encompass:</p> <ul style="list-style-type: none"> •Transfer assessment: Transfer assessments will be performed by having DON or Designee observed five nursing staff perform transfers weekly. A log will be completed to ensure necessary components of transfer are performed. These components including preparing the patient for transfer, proper equipment setup such as locking wheelchair brakes and removing footrests, transferring the patient safely, and setting up equipment properly for patient after transfer, such as putting wheelchair footrests and arm rests back in place. •Patient interviews: Patient Interviews will focus on patient satisfaction and overall care. •Plan of care audits: POC audits will assess implementation of care plan. •Monitoring of change of condition reporting. Change of Condition reporting will monitor physician notification, involvement, and follow-up occurs as appropriate. Deficient practices will be discussed promptly with the Director of Nursing and Administrator and corrective action will be taken. Audit results will be reported by the Director of Nursing to Sub-acute Rehabilitation Facility Quality Assurance Performance Improvement Committee monthly x 3 months for further monitoring and recommendations, then quarterly thereafter. <p>5) Date of Compliance 8/01/14.</p>		

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F 309	<p>Continued From page 14</p> <p>relieved with relaxation techniques and prn Tramadol given for hip pain." However no mention was made of the 9:15 PM incident or any nursing assessment following the incident. At 5:00 AM ann RN documented the resident, "had a restful night, had no further complaints and was medicated with Tramadol X 2 as ordered."</p> <p>*On 6/5/14 at 1:30 PM the DON documented that she visited the resident at the request of the medical director. The DON's note addressed that she reassured and comforted the confused resident but did not address the incident or any physical assessment of the resident in relationship to the incident. The DON documented she would monitor the resident's status.</p> <p>*PCN - 6/6/14 referenced the use of foot pedals at 11:49 AM. In the note the DON documented she continued,"... to monitor the [resident's] care numerous times/day... appeared alert and oriented [times 2] this am. Sitting upright in wheelchair getting assistance with grooming... appeared well groomed and comfortable with no guarding or facial grimacing with movement ... continues to lean to the [right] when sitting in the wheelchair and struggles with repositioning herself but appreciates assistance when given. Foot rests are in place on the wheelchair as well as reminders to staff to use 100% of the time."</p> <p>The resident's clinical/medical record, dated 6/7/14 through 6/12/14 made no other mention of/reference to the 6/4/14 incident or the resident's status in relationship to the incident. There was still no documentation the resident's physician(s) had been notified of the incident.</p>	F 309		

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F 309	<p>Continued From page 15</p> <p>*Hospital Rounds - 6/12/14 at 6:27 PM documented, "[The resident] was discussed in staffing... Present in staffing were physical and occupational therapy, nursing staff, social services, case management, program directors, and nutrition services... The [resident's] functional status has declined because of issues related to her left hip... and weight bearing precautions. This needs to be addressed further with [Resident's orthopedic surgeon]. I have left a message for him. He should be in town. Obviously, these things were discussed with [the two physician's who reviewed the 6/4/14 x-ray]. No acute surgical intervention has been recommended."</p> <p>Note: The 6/4/14 x-ray reviewed by the two physician's was taken at 1:00 PM, eight hours before the second incident occurred at 9:15 PM. The physician's recommendations of, "no acute surgical intervention" was based on review of the x-ray taken prior to the second incident.</p> <p>No x-ray was taken following the 6/4/14 incident until 6/16/16. A Hospital Rounds note dated 6/16/14 at 8:29 PM documented, "The [resident] does have a periprosthetic fracture which became more apparent on the second x-ray. He is recommending surgical revision as a possibility versus non weight bearing." There was still no documentation that the physician completing this report had been made aware of the 6/4/14 incident when the resident's left foot drug under the chair and may have resulted in re-injury to the resident's left surgical hip.</p> <p>Resident #1's medical record from 6/5/14 through 6/19/14 revealed the resident received more pain and antianxiety medications after the 6/4/14</p>	F 309			

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F 309	<p>Continued From page 16 incident than before. For example:</p> <p>Medication Administration Records (MAR) documented the resident received one pm dose of Tramadol for pain on the morning of 5/31/14, and the evenings of 6/2/14, and 6/3/14. On 6/4/14 she received pm Tramadol at 2:11 PM and 8:12 PM. Following the incident on the evening of 6/4/14, Resident #1's MAR documented she received 1 to 3 doses of pm Tramadol per day and received two doses of Oxycodone (a narcotic pain reliever) on 6/7/14, and one dose on 6/12/14, and 6/15/14. The MAR also documented the resident received pm doses of Ativan, for anxiety, on 6/6/14 and 6/13/14.</p> <p>POP, PCN and Hospital Rounds notes for 6/4/14 - 6/19/14. *PCN Note: 6/5/14 at 12:34 AM - "Experiencing severe pain." *PCN Note: 6/8/14 at 12:41 and 5:14 PM - "Confused, hallucinating... scratching and swatting at staff." *PCN Note: 6/9/14 at 3:18 PM - "[Resident] very confused with pain today..." *PCN Note: 6/10/14 at 8:20 AM - The told RN, "My hip hurts so bad." *PCN Note: 6/11/14 at 10:21 AM - " Confused, tired, unable to rate pain." *PCN Note: 6/12/14 at 1:13 PM - "Complained of some pain left inner thigh *PCN and POPN notes: 6/12/14 - 6/16/19 - documented the resident was transported to her Orthopedic Surgeon's office by the resident's family on 6/16/14 for a scheduled routine follow-up appointment. Later on the evening of 6/16/14, at 8:29 PM, the resident's physician documented on a Hospital Rounds Note, "The [resident] does have a periprosthetic fracture</p>	F 309			

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

PRINTED: 07/28/2014
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 C 06/27/2014
NAME OF PROVIDER OR SUPPLIER ID ELKS REHAB HOSP SUBACUTE REHAB UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 600 NORTH ROBBINS ROAD, 83702-4539 BOISE, ID 83701		
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F 309	<p>Continued From page 17</p> <p>which became more apparent on the second x-ray He is recommending surgical revision as a possibility versus non weight bearing." Note: The first x-ray referred to by this physician was taken at 1:15 PM on 6/4/14, approximately 8 hours before the incident on 6/4/14 at 9:15 PM when the residents left foot drug under her wheelchair during a transport to/from the bathroom. A second x-ray was not taken until the resident's already scheduled, routine follow-up visit, to her orthopedic surgeon. *POPN: 6/16/19 at 3:50 PM - "Pt is scheduled for surgery [at] 6/19 at 12:30 [PM] with a 10:30 [AM] check in." *POPN: 6/16/19 noted at 8:20 PM- Physician's order, "No OOB [Out of Bed] activity, NWB [Non weight bearing], Only experienced CNAs to transfer/handle resident."</p> <p>PCNs for 6/16/14 and 6/17/14 documented the resident was placed on bedrest on 6/16/14. The resident's PCNs and MARs for 6/16 - 6/19 documented the resident received/required no breakthrough pain medication or prn antianxiety medication, after she was placed on bedrest on 6/16/14. The resident did continue to receive her scheduled acetaminophen 1000 mg every eight hours.</p> <p>A 6/19/14 consultation note by the hospital internal medicine hospitalists documented, "On follow-up earlier this week, an x-ray was performed which showed the patient to have a fairly severe periprosthetic fracture and she was taken to OR [Operating Room] this evening for revision to a left total hip. While talking with [the resident's orthopedic surgeon], it appears there was a fair amount of bleeding... and the patient received 4 units of packed cells in OR... Prior to</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 309	<p>Continued From page 18</p> <p>the patient's surgery there may have been some incident at [facility] where the patient caught her foot while being wheeled in a wheelchair and had some pain associated with that. The family is not sure if this may have led to the periprostatic fracture. It is unclear..."</p> <p>On 6/27/14 at 9:25 AM, the DON was interviewed regarding the 6/4/14 incident in which the resident's surgical leg was drug under the wheel chair due to a failure of staff to use foot pedals. The DON stated the first she heard about the incident was on 6/5/14 when the Program Manager told her the resident's family had filed a complaint. The DON stated she spoke with CNAs #1 & 2, who were involved in the incident, on 6/5/14. The two CNAs stated they did leave the foot pedals off the resident's wheelchair during the transfer on 6/4/14 at 9:15 PM.</p> <p>During the interview the DON stated she visited with the resident on 6/5/14 at the request of the residents assigned physician who was concerned with the family member's, "Worry about care." The DON stated she and the physician did not talk about the wheelchair incident or the lack of use of the foot pedal. The DON stated she assumed the physician knew about the incident. The DON stated she visited with the resident, who was confused at the time, and "reassured her." The DON stated the resident tended to be a bit histrionic, yelled frequently for help, would yell about pain and then be forgetful about, "Why she had pain." The DON stated neither she, nor any nurse, had completed a physical assessment of the resident specifically related to the incident. The DON further stated that they were not convinced that the resident had been injured during the incident on 6/4/14 at 9:15 PM, because</p>	F 309			

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F 309	<p>Continued From page 19</p> <p>the x-rays taken on the 4th and reviewed by 3 physician's, did not show an acute injury. When the time frame of the x-ray taken on 6/4/14 at 1:15 PM and the time frame of the incident on the evening of 6/4/14 at 9:15 PM (eight hours after the x-ray) were reviewed with the DON, the DON indicated she, not staff, realized that the x-ray did not cover the 6/4/14 9:15 PM incident.</p> <p>The DON was asked to provide any documentation available that demonstrated the physicians were aware of the incident on 6/4/14 at 9:15 PM, that a second set of x-rays were considered after the incident and before the 6/16/14 follow-up visit to the surgeon, that nursing, therapy, or medical staff considered the possibility that the resident's increased pain and decreased function, after the 6/4/14 incident, required further follow-up. The DON was unable to provide additional documentation.</p> <p>The Acting Administrator, DON, and Program Manager were notified of these findings on 6/27/14 at 1:15 PM. No additional information was provided.</p>	F 309			

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 06/27/2014
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NAME OF PROVIDER OR SUPPLIER ID ELKS REHAB HOSP SUBACUTE REHAB UA	STREET ADDRESS, CITY, STATE, ZIP CODE 600 NORTH ROBBINS ROAD, 83702-4539 BOISE, ID 83701
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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the complaint investigation conducted at your facility. The surveyors conducting the survey were: Susan Gollobit RN, Team Leader Lorraine Hutton, RN The survey team entered the facility on Thursday, June 26, 2014 and exited the facility on Friday, June 27, 2014.	C 000		
C 175	02.100.12,f Immediate Investigation of Incident/Injury f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Refer to F225 as it relates to investigation of incidents and accidents to rule out abuse or neglect.	C 175	C175 • See F 225 for Plan of Correction	8/01/14
C 784	02.200.03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to:	C 784	C784 • See F 309 for Plan of Correction	8/01/14

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AUG 01 2014
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Joseph P. Carroll</i>	TITLE <i>NH Administrator</i>	(X6) DATE <i>8/1/14</i>
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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 06/27/2014
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C 784	Continued From page 1 This Rule is not met as evidenced by: Refer to F 309 as it relates to delay in care and treatment.	C 784		
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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

July 22, 2014

Joseph Caroselli, Administrator
Idaho Elks Rehab Hosp Subacute Rehab Unit
PO Box 1100
Boise, ID 83701-1100

FILE COPY

Provider #: 135114

Dear Mr. Caroselli:

On **June 27, 2014**, a Complaint Investigation survey was conducted at Idaho Elks Rehab Hosp Subacute Rehab Unit. Susan Gollobit, R.N., and Lorraine Hutton, R.N., conducted the complaint investigation.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006529

ALLEGATION #1:

In a complaint received via another another agency, a complainant documented that on June 6, 2014, at 9:00 p.m., an identified resident who was at the facility for rehabilitation related to a left hip replacement was transferred to a wheelchair and then transported to and from the bathroom without foot pedals or leg rests on the wheelchair.

The complainant documented that during the transfer the resident's left leg and foot was partially drug under the chair because it was not properly supported. This caused the resident's left hip to rotate out and her left leg to rotate in. As a result, the identified resident immediately experienced great pain, discomfort and anxiety.

FINDINGS:

A complaint investigation was conducted on June 26, 2014 and June 27, 2014.

During the investigation, the following records were reviewed:

- Incident and Accident reports for June 2014;
- Grievance records for April 2014 through June 2014;
- Medical records of three residents, includes the identified resident; and
- Facility's policy and procedures for preventing and reporting incidents, accidents and abuse.

In addition, interviews were conducted with the Acting Administrator, Director of Nursing Services, Compliance Officer, as well as licensed nursing staff and certified nurse aides.

During the investigation, the allegation was substantiated and the facility was cited for failing to properly transfer a resident and assess the resident after the improper transfer. Please refer to F309 on the Federal Survey Report (CMS-2567).

CONCLUSION:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant documented that the identified resident's physician ordered a new x-ray, "to determine why the extra pain was occurring." The x-ray was reviewed by two separate doctors who determined a secondary fracture could be evident. Further review was postponed until the surgeon on record could be contacted for review.

Follow-up with the surgeon occurred on June 16, 2014, and an x-ray taken at the surgeon's office was positive for "significant secondary fracture," to the resident's left hip. Surgical repair was recommended and tentatively scheduled for Thursday, June 19, 2014.

FINDINGS:

During the investigation, the allegation was substantiated and the facility was cited for failing to notify the attending physician or orthopedic physician, in a timely manner, after the resident was improperly transferred and experienced increased pain with decreased functional status. Please refer to F309 on the Federal Survey Report (CMS-2567).

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Joseph Caroselli, Administrator
July 22, 2014
Page 3 of 3

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The letters are somewhat stylized and slanted.

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

LK/lj