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

FILE COPY

**CERTIFIED MAIL: 7012 1010 0002 0836 2502**

July 10, 2013

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

Provider #: 135114

Dear Mr. Caroselli:

On **July 2, 2013**, a Recertification and State Licensure survey was conducted at Idaho Elks Rehabilitation Hospital and SubAcute Rehabilitation Unit by the Department of Health & Welfare, 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE**: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 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 Form 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 23, 2013**. Failure to submit an acceptable PoC by **July 23, 2013**, may result in the imposition of civil monetary penalties by **August 12, 2013**.

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 you will make to ensure that the deficient practice does not recur;

- How the corrective action(s) will be monitored to ensure the deficient practice will 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 has 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 5.

  If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **August 6, 2013 (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 6, 2013**. A change in the seriousness of the deficiencies on **August 6, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 6, 2013** includes the following:

Denial of payment for new admissions effective **October 2, 2013**. [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 **January 2, 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, it will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; 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 **July 2, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx

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

- BFS Letters (06/30/11)

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

This request must be received by **July 23, 2013**. If your request for informal dispute resolution is received after **July 23, 2013**, 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, please contact us at (208) 334-6626.

Sincerely,

LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj
Enclosures

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

PRINTED: 07/10/2013
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135114 | | 07/02/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ID ELKS REHAB HOSP SUBACUTE REHAB UNIT | 600 NORTH ROBBINS ROAD, 83702-4565<br>BOISE, ID 83701 |

| (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 | INITIAL COMMENTS<br><br>The following deficiencies were cited during the Federal recertification survey of your facility.<br><br>The surveyors conducting the survey were:<br>Karen Marshall, MS, RD, LD Team Coordinator<br>Nina Sanderson, BSW, LSW<br>Amy Jensen, RN<br>Bradley Perry, BSW, LSW<br><br>Survey Definitions:<br>ADLs = Activities of Daily Living<br>DM = Dietary Manager<br>DON = Director of Nursing<br>LN = Licensed Nurse<br>MDS = Minimum Data Set assessment<br>PM = Program Manager<br>RN = Registered Nurse | F 000 | RECEIVED<br>AUG - 2 2013<br>FACILITY STANDARDS | |
| F 156<br>SS=C | 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES<br><br>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.<br><br>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the | F 156 | **F156:** Language regarding Dietary Services, Activities, and Medically Related Social Services will be placed into the admission document "Covered Services and Charges for the Subacute Unit". This document is placed in the patient's personal "Journey Book" upon admission, and receipt of it is documented by initialing an acknowledgment form. Frequency of Monitoring: This process is monitored by the "Patient Experience Specialist". He will keep a log of every admitted patient and note that they have received this "Covered Services and Charges" form. The Subacute | 7-23-13 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Joseph P. Arnold | CEO | 8/1/13 |

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 156 | Continued From page 1<br>items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.<br><br>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.<br><br>The facility must furnish a written description of legal rights which includes:<br>A description of the manner of protecting personal funds, under paragraph (c) of this section;<br><br>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.<br><br>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State | F 156 | Program Director will review this log monthly (at the end of the month) for 6 months. The start date of data collection will be August 1, 2013. The first audit by the program director will be August 31, 2013. | 8-31-13 |

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| F 156 | Continued From page 2<br>ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.<br><br>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.<br><br>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on review of the facility's admission agreement and staff interview, it was determined the facility did not ensure residents were fully informed of their rights at the time of admission. This was true for all sampled residents (#s 1-8), and any resident admitted to the facility. Findings included:<br><br>The facility's admission agreement was reviewed on 7/2/13 as part of the standard survey process. The agreement did not include language informing residents dietary services, an activities program, and medically related social services | F 156 | | |

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| F 156 | Continued From page 3<br>were covered in the course of a Medicare stay.<br><br>On 7/2/13 at 10:00 AM, the Resident Experience Specialist (RES) was asked about the information missing from the admission agreement. The RES stated he would investigate further.<br><br>On 7/2/13 at 1:05 PM, the PM approached the surveyor with additional information. However, this information did not help to resolve the concerns.<br><br>On 7/2/13 at 1:45 PM, the PM and DNS were informed of these findings. The facility offered no further information. | F 156 | | |
| F 309<br>SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interview, and record review, it was determined the facility did not ensure residents received medication per physician's orders, and did not follow their bowel protocol for a resident who had not had a bowel movement for 3 days. This was true for 2 of 7 residents (#s 2 and 4) sampled for medications and bowel care. The deficient practice had the potential to cause more than | F 309 | **F309:** Resident #4: Reviewed patient's chart to ensure no harm was caused by the omitted dose of medication or additional information for the Survey team (none found).<br><br>The omitted dose of Colace without documentation was addressed through our Medication Administration policy (NS0601, "Documentation 4.d. Missed Dose. Document missed dose reason". Per policy NS0603 ("Medication Errors/Adverse Drug Reaction/No EMAR Charting, 11. Reportable Categories A. Omission - dose not given), a Medication Safety Alert form was completed.<br><br>Per Elks Nursing procedure, the nurse involved was counseled. | 7-2-13<br><br>7-3-13<br><br>7-15-13 |

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| F 309 | Continued From page 4<br>minimal harm if residents became constipated or developed fecal impaction. Findings included:<br><br>1. Resident #4 was admitted to the facility on 6/24/13 for a primary diagnosis of CVA, along with with diagnoses of pain and constipation.<br><br>Resident #4 did not yet have an MDS completed at the time of survey.<br><br>Resident #4's medication orders on 6/24/13 at the time of her admission included the following medications for constipation:<br>-Colace 100 milligrams (mg) twice daily for constipation. (NOTE: There was no documentation as to what time the medication should be given.)<br>-Milk of Magnesia 30 cubic centimeters (cc) twice daily as needed if no bowel movement in more than 24 hours.<br>-Dulcolax tablets every 12 hours as needed if no bowel movement in more than 24 hours.<br><br>Resident #4's input/output record documented no bowel movements on 6/24/13, 6/25/13, 6/27/13, 6/28/13, and 7/2/13.<br><br>Resident #4's MAR for 6/26/13 documented only one dose of Colace was given, at 5:56 PM.<br><br>On 6/26/13 at 5:45 PM, Resident #4's Physician's orders and Progress notes documented, "Bisacodyl suppository 1 only PR [per rectum] X 1 for constipation."<br><br>On 6/27/13 at 2:10 PM, Resident #4's Physician's orders and Progress notes documented, "Bisacodyl supp[ository] 10 mg PR X 1 for | F 309 | Policies NS 601 and NS 603 will be reviewed and discussed at the next staff meeting.<br><br>Start date of audits? Previously ongoing.<br><br>Start date of pharmacy will report to Nursing? 8-1-13<br><br>Length of audit to be 3 months. 8/14/13<br><br>How often will audits be done? The Elks pharmacy audits omitted drug documentation as part of their daily medication delivery process with every patient. The pharmacy will report to nursing when a drug was omitted without documentation. The Nurse Educator will address documentation omissions with staff members.<br><br>Who will do the audits? Pharmacy<br><br>How often? Pharmacy – Monday through Saturday. Nursing – Whenever reported.<br><br>Resident #2. Patient was admitted 6/21/13 and stated she had a BM that day6. Patient reported to MD on 6/21/13 that she has a history of constipation and was not | 7-19-13<br><br>8-1-13 |

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| F 309 | Continued From page 5<br>constipation."<br><br>On 7/2/13 at 9:00 AM, RN # 2 was interviewed regarding Resident #4. RN #2 was asked what times Resident #4's Colace should have been administered. RN #2 reviewed Resident #4's physician's orders and stated, "Looks like 8:00 AM and 6:00 PM." RN #2 was asked about documentation to show Resident #4 had received her Colace the morning of 6/26/13. RN# 2 further reviewed Resident #4's record, and found a form which documented a dose of Colace was missed on 6/26/13 at 8:30 AM. No reason was given for the missed dose. RN #2 was asked if Resident #4's orders for a suppository on 6/26/13 and 6/27/13 could be related to the missed dose of Colace on 6/26/13. RN #2 stated, "I don't know. I suppose so."<br><br>On 7/2/13 at 1:45 PM, the DNS and PM were informed of the surveyor's findings. The facility offered no further information.<br><br>2. Resident #2 was admitted to the facility on 6/21/13 with multiple diagnoses including aftercare for traumatic fractures, anemia, muscle spasms, and nerve pain.<br><br>The facility's Bowel Program Policy, Appendix A, included, in part,<br>"...Step 2; use if 24 hrs since LBM [24 hours since last bowel movement] Start Docusate 100 mg po BID [milligrams by mouth two times a day]. Indications - Consider this in patients who...are taking narcotics...If no results, DC [discontinue] Docusate and go to the next column [step].<br>Step 3; use if 48 hrs since LBM Start Miralax 17 g | F 309 | was not uncomfortable. As a rehabilitation facility, we have several CRRN's that have, as part of their national certification, advanced knowledge of bowel programs. We try to establish a patient's individual bowel pattern before interventions are established and to change interventions no more than once a day.<br><br>On the morning of 6/24/13, the RN initiated bowel interventions. The physician initiated an additional intervention. The physician order overrides the Bowel Program protocol. There is no documentation of the patient reporting any issues. The patient was monitored for 24 hours before interventions were changed. The patient had a BM on 6/25/13.<br><br>Patient's chart was reviewed and discussed with Surveyor Marshall. No harm noted.<br><br>Will review current Bowel Program procedure by 8-1-13.<br><br>Will correct/change any updated information by 8-5-13.<br><br>Will provide Bowel Care Education to the Nursing Team Leaders (RNs) on 7-17-13. | 7-2-13<br><br>8-1-13<br><br>8-5-13<br><br>7-17-13 |

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| F 309 | Continued From page 6<br>in 8 oz [grams in 8 ounces] water po daily OR Senna 1 tab [tablet] po BID OR Senna-S 1 tab po BID per Patient/RN preference. Indications - consider one of these in patients who have gone 2 days since LBM, are on constipating medications, narcotics...If no results go to next column.<br>Step 4; use if 72 hrs since LBM order MOM 30 ml po x1 [Milk of Magnesia 30 milliliters po one time]. Indications - consider this step in patients who have gone 3-4 days since LBM and have no renal compromise; expect results within 6 hours..."<br><br>Resident #2 did not yet have an MDS completed at the time of survey.<br><br>Resident #2's Medication Administration Record and medical record provided evidence on admission the resident's physician ordered and the resident received the following medications. These medications have possible side effects of constipation.<br>- Percocet (acetaminophen and oxycodone) 10 milligrams (mg) every 4 hours as needed (hrs prn)<br>- Lyrica (pregabalin) 75 mg twice daily<br>- Ferrous gluconate (iron supplement) 324 mg twice daily<br><br>Resident #2's Care Plan printed 7/2/13 identified the 6/21/13 problem, has an actual or potential change in bowel pattern. Goal, will regain normal pattern of bowel function. Two interventions: assess elimination pattern and verify need of bowel meds (medications) prior to giving.<br>NOTE: The Care Plan did not identify what the resident's normal bowel function was prior to admission. | F 309 | Will provide Bowel Care Education and monitoring to general staff on 7-19-13.<br><br>We will provide followup documentation to Idaho Health & Welfare of our actions by 8-15-13.<br><br>Team Leaders will document on a specific flowsheet a chart audit of bowel assessments and interventions on 2 patients a day.<br><br>Start of audits: 8-1-13<br><br>Length of time audit will be done? 3 months. 8/14/13<br><br>How often will audits be done? Monday – Saturday.<br><br>Who will do the audits? Nursing Team Leaders. | 7-19-13<br><br>8-15-13<br><br><br><br>8-1-13 |

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| F 309 | Continued From page 7<br><br>The resident's electronic Intakes/Outputs form documented the resident had a BM on 6/21/13 at 9:04 p.m. and did not have another BM until 6/25/13 at 10:13 p.m. A total of 4 days.<br><br>Resident #2's Physician's Orders and Progress Notes form contained a column for Progress Notes (PNs) and another column for Doctor's Orders. The form documented in part,<br>* PNs column, "6/24 [2013], LBM 6/21 [2013]." Doctor's Orders column, "MOM 30 ml po x1, & Docusate 100 mg po BID, first dose this evening..."<br>* Doctor's Orders column, "6/24/13 at 9:30 a.m...Miralax 17 g daily - 1st [first] dose today..."<br>* Doctor's Orders Column, "6/24/13 at 10:20 a.m., DC [discontinue] Colace..."<br>* PNs column, "6/24/13 Pt [patient] requesting for Colace. [MD's name] note in rounds to have Miralax [indistinguishable entry] regimen [with] colace..." Doctor's Orders Column, "Colace 100 mg po BID..."<br><br>On 7/2/13 at 8:27 a.m., the surveyor informed RN #2 Resident #2 had a BM on 6/21/13, did not have a BM on 6/22/13 or 6/23/13, was administered medication on 6/24/13, and then had a BM on 6/25/13. The resident was without a BM for 3 days before interventions were implemented. The surveyor and the RN then reviewed the resident's entire medical record, Medication Administration Record, electronic Patient Care Notes and bowel movements (Intakes and Outputs), Care Plan, Physician's Orders and Progress Notes, and guidance to CNAs (Kardex). The RN stated, "Nothing [no medication] was started until 6/24/13. An | F 309 | | |

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|---|---|---|---|
| | 135114 | | 07/02/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ID ELKS REHAB HOSP SUBACUTE REHAB UNIT | 600 NORTH ROBBINS ROAD, 83702-4565<br>BOISE, ID 83701 |

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| F 309 | Continued From page 8<br>intervention should have been started sooner than 6/24/13."<br><br>On 7/2/13 at 1:50 p.m., the surveyor informed the DON and the PM of the above finding. The DON stated, "I will check the record." At approximately 2:00 p.m., the DON stated, "The record shows the resident had a BM on 6/21/13, no BM on 6/22/13 and 6/23/13, medication was administered on 6/24/13, and then Resident #2 had a BM on 6/25/13."<br><br>On 7/2/13 at 2:30 p.m., the Administrator was informed Resident #2 was without a BM for 3 days before interventions were implemented for the resident. | F 309 | | |
| F 371<br>SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions | F 371 | **F371:** Slicer was reported by H&W inspector to be not adequately cleaned. Slicer was immediately re-cleaned by kitchen employee. Food prep personnel will be instructed to visually inspect all surfaces of appliance after cleaning and sanitizing to ensure that appliance is completely clean. | 7-2-13 |
| | This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, it was determined the facility failed to prepare food under sanitary conditions. This affected 6 of 7 (#s 1-5 & 7) sampled residents and had the potential to affect residents who dined in the facility.<br>Findings included: | | Kitchen supervisor on duty will inspect slicer at end of each workday to ensure that it has been properly cleaned. A monitoring log-sheet will be created and posted so that supervisor can indicate that daily monitoring has been followed.<br><br>Log sheet will be posted on or before Friday, 8-2-13. | ongoing<br><br>8-2-13 |

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| F 371 | Continued From page 9<br><br>On 7/1/12 at 10:25 a.m. the Dietary Manager (DM) accompanied the surveyor during the initial tour of the facility's kitchen. At 10:42 a.m., the slicer was on a counter with a plastic cover over the slicer. The DM removed the plastic cover. The slicer blade and frame were observed with what appeared to be red-brown colored food particles on both of the surfaces. The frame surface also had what appeared to be red-brown colored dried liquid. The DM stated, "The slicer needs to be cleaned." Kitchen staff were watching the surveyor and DM and one of the staff immediately began cleaning the slicer.<br><br>On 7/2/13 at 1:24 p.m., the DM stated, "It [the slicer] should have been cleaned [when we looked at it]."<br><br>The slicer blade and frame were not clean to sight and touch.<br><br>The 2009 FDA Food Code, Chapter 4, Part 4-6, Cleaning of Equipment and Utensils, Subpart 601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils indicated, "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch... (C) Non food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."<br><br>On 7/2/13 at 2:30 p.m., the Administrator and the DON were informed of the finding. | F 371 | | |

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| | MDS001290 | | 07/02/2013 |

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| C 000 | 16.03.02 INITIAL COMMENTS<br><br>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.<br>The following deficiencies were cited during the State licensure survey of your facility.<br><br>The surveyors conducting the survey were:<br>Karen Marshall, MS, RD, LD Team Coordinator<br>Nina Sanderson, BSW, LSW<br>Amy Jensen, RN<br>Bradley Perry, BSW, LSW | C 000 | **C118:** Language regarding Dietary Services, Activities, and Medically Related Social Services will be placed into the admission document "Covered Services and Charges for the Subacute Unit". This document is placed in the patient's personal "Journey Book" upon admission, and receipt of it is documented by initialing an acknowledgment form. Frequency of Monitoring: This process is monitored by the "Patient Experience Specialist". He will keep a log of every admitted patient and note that they have received this "Covered Services and Charges" form. The Subacute Program Director will review this log monthly (at the end of the month) for 6 months. The start date of data collection will be August 1, 2013. The first audit by the program director will be August 31, 2013. | 7-23-13<br><br>8-31-13 |
| C 118 | 02.100,03,c,ii Available Services and Charges<br><br>ii. Is fully informed, prior to or at the time of admission and during stay, of services available in the facility, and of related charges including any charges for services not covered under Titles XVIII or XIX of the Social Security Act, or not covered by the facility's basic per diem rate;<br>This Rule is not met as evidenced by:<br>Please see F 156 as it pertains to the facility's admission agreement. | C 118 | | |
| C 325 | 02.107,08 FOOD SANITATION<br><br>08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." | C 325 | **C325:** Slicer was reported by H&W inspector to be not adequately cleaned. Slicer was immediately re-cleaned by kitchen employee. Food prep personnel will be instructed to visually inspect all surfaces of appliance after cleaning and sanitizing to ensure that appliance is completely clean. Kitchen supervisor on duty will inspect slicer at end of each workday to ensure that it has been | 7-2-13<br><br>Ongoing |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 8/1/13

Bureau of Facility Standards

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| | MDS001290 | | 07/02/2013 |

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| C 325 | Continued From page 1<br>This Rule is not met as evidenced by:<br>Please refer to F371 as it related to the slicer blade and frame. | C 325 | properly cleaned. A monitoring log-sheet will be created and posted so that supervisor can indicate that daily monitoring has been followed. Log sheet will be posted on or before Friday, 8-2-13. | 8-2-13 |
| C 784 | 02.200,03,b Resident Needs Identified<br>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:<br>This Rule is not met as evidenced by:<br>Please see F 309 as it pertains to bowel care and physician's orders. | C 784 | **C784:** Resident #4: Reviewed patient's chart to ensure no harm was caused by the omitted dose of medication or additional information for the Survey team (none found). | 7-2-13 |
| | | | The omitted dose of Colace without documentation was addressed through our Medication Administration policy (NS0601, "Documentation 4.d. Missed Dose, Document missed dose reason". Per policy NS0603 ("Medication Errors/Adverse Drug Reaction/No EMAR Charting, 11. Reportable Categories A. Omission - dose not given), a Medication Safety Alert form was completed. | 7-3-13 |
| | | | Per Elks Nursing procedure, the nurse involved was counseled. | 7-15-13 |
| | | | Policies NS 601 and NS 603 will be reviewed and discussed at the next staff meeting. | 7-19-13 |
| | | | Start date of audits? Previously ongoing. | |
| | | | Start date of pharmacy will report to Nursing? 8-1-13 | 8-1-13 |

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| C 325 | Continued From page 1<br><br>This Rule is not met as evidenced by:<br>Please refer to F371 as it related to the slicer blade and frame. | C 325 | Length of audit to be 3 months.<br>9/19/13 | |
| C 784 | 02.200,03,b Resident Needs Identified<br><br>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:<br>This Rule is not met as evidenced by:<br>Please see F 309 as it pertains to bowel care and physician's orders. | C 784 | How often will audits be done?<br>The Elks pharmacy audits omitted drug documentation as part of their daily medication delivery process with every patient. The pharmacy will report to nursing when a drug was omitted without documentation. The Nurse Educator will address documentation omissions with staff members.<br><br>Who will do the audits? Pharmacy<br><br>How often? Pharmacy – Monday through Saturday. Nursing – Whenever reported.<br><br>Resident #2. Patient was admitted 6/21/13 and stated she had a BM that day6. Patient reported to MD on 6/21/13 that she has a history of constipation and was not uncomfortable. As a rehabilitation facility, we have several CRRN's that have, as part of their national certification, advanced knowledge of bowel programs. We try to establish a patient's individual bowel pattern before interventions are established and to change interventions no more than once a day. | |

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| C 325 | Continued From page 1<br>This Rule is not met as evidenced by:<br>Please refer to F371 as it related to the slicer blade and frame. | C 325 | On the morning of 6/24/13, the RN initiated bowel interventions. The physician initiated an additional intervention. The physician order overrides the Bowel Program protocol. There is no documentation of the patient reporting any issues. The patient was monitored for 24 hours before interventions were changed. The patient had a BM on 6/25/13. | |
| C 784 | 02.200,03,b Resident Needs Identified<br>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:<br>This Rule is not met as evidenced by:<br>Please see F 309 as it pertains to bowel care and physician's orders. | C 784 | Patient's chart was reviewed and discussed with Surveyor Marshall. No harm noted. | 7-2-13 |
| | | | Will review current Bowel Program procedure by 8-1-13. | 8-1-13 |
| | | | Will correct/change any updated information by 8-5-13. | 8-5-13 |
| | | | Will provide Bowel Care Education to the Nursing Team Leaders (RNs) on 7-17-13. | 7-17-13 |
| | | | Will provide Bowel Care Education and monitoring to general staff on 7-19-13. | 7-19-13 |
| | | | We will provide followup documentation to Idaho Health & Welfare of our actions by 8-15-13. | 8-15-13 |
| | | | Team Leaders will document on a specific flowsheet a chart audit of | |

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| C 325 | Continued From page 1<br><br>This Rule is not met as evidenced by:<br>Please refer to F371 as it related to the slicer blade and frame. | C 325 | bowel assessments and interventions on 2 patients a day.<br><br>Start of audits: 8-1-13 | 8-1-13 |
| C 784 | 02.200,03,b Resident Needs Identified<br><br>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:<br>This Rule is not met as evidenced by:<br>Please see F 309 as it pertains to bowel care and physician's orders. | C 784 | Length of time audit will be done? 3 months. 8/14/13<br><br>How often will audits be done? Monday – Saturday.<br><br>Who will do the audits? Nursing Team Leaders. | |