



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

January 23, 2017

Nolan Hoffer, Administrator
Id Elks Rehabilitation Hosp Subacute Rehab Unit
Po Box 1100
Boise, ID 83701-4539

Provider #: 135114

Dear Mr. Hoffer:

On **January 11, 2017**, a survey was conducted at St Luke's Rehab - Elks Sub Acute Rehab Unit by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 2, 2017**. Failure to submit an acceptable PoC by **February 2, 2017**, may result in the imposition of penalties by **February 23, 2017**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **February 15, 2017 (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 **April 11, 2017**. A change in the seriousness of the deficiencies on **February 25, 2017**, may

result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 11, 2017** includes the following:

Denial of payment for new admissions effective **April 11, 2017**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 10, 2017**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **April 11, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

Nolan Hoffer, Administrator
January 23, 2017
Page 4

<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:

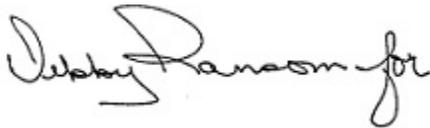
- BFS Letters (06/30/11)

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

This request must be received by **February 2, 2017**. If your request for informal dispute resolution is received after **February 2, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,



Nina Sanderson, LSW, Supervisor
Long Term Care

ns/lj
Enclosures

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

PRINTED: 02/10/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/11/2017
NAME OF PROVIDER OR SUPPLIER ST LUKE'S REHAB - ELKS SUB ACUTE REHAB UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 600 NORTH ROBBINS ROAD BOISE, ID 83702		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility from January 9, 2017 through January 11, 2017. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Linda Kelly, RN Survey Abbreviations: CAD = Coronary Artery Disease CHF = Congestive Heart Failure CDM = Certified Dietary Manager FDA = Food and Drug Administration I&O = Intake & Output LN = Licensed Nurse LPM = Liters Per Minute MAR = Medication Administration Record MI = Myocardial Infarction (heart attack) NC = Nasal Cannula O2 = Oxygen PRN = As Needed RN = Registered Nurse RT = Respiratory Therapy SpO2 = Oxygen Concentration URI = Upper Respiratory Infection UTI = Urinary Tract Infection	F 000			
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care	F 279		2/14/17	

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

TITLE

(X6) DATE

Electronically Signed

02/02/2017

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 279	Continued From page 1 plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and	F 279			

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F 279	<p>Continued From page 2 desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, observation, and record review, it was determined the facility failed to ensure an indwelling urinary catheter care plan was in place for 1 of 1 sample residents (#1) with an indwelling urinary catheter. The failure created the potential for Resident #1 to not receive the appropriate care and treatment which could lead to decline in his health. Findings include: Resident #1 was admitted to the facility on 1/5/17 with multiple diagnoses, including CHF and UTI. On 1/9/17 at 1:15 pm, Resident #1 was observed sitting in a wheelchair by his bed. Urinary drainage tubing was visible under the wheelchair and clear, pale yellow urine was noted in the tubing. Resident #1 said a urinary catheter was in place because of problems with his bladder and he could not urinate without it. Resident #1's facility admission orders included, "Initiate Bladder Protocols Until discontinued"</p>	F 279	<p>The Director of Nursing is ultimately responsible for ensuring indwelling urinary catheter placement is reflected in the plan of care for appropriate residents. Resident #1 was discharged prior to receiving the final survey report. Residents with indwelling catheters were identified and medical record reviewed to ensure that care management documentation for indwelling urinary catheter is in place.</p> <p>Plan of Correction: •Electronic Health Record (EHR) modified to reflect care management documentation for indwelling urinary catheter completed- 2/1/17 •Clinical nursing staff educated on the expectations to document the presence of the indwelling urinary catheter to be completed by 2/14/17</p>		

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F 279	Continued From page 3 and "intake and output Every 12 hours," both of which were ordered 1/5/17 at 4:44 pm. An order for an indwelling urinary catheter was not included in Resident #1's current orders. Resident #1's active care plan included, "Goal: Rehab Promote Bladder Continence Plan" started 1/6/17. On 1/6/17 at 12:47 am, the outcome was documented as "Met/Ongoing." On 1/7/17 at 10:10 am, "Promote bladder continence plan" and "Toileting Schedule" was noted and at 1:58 pm, the outcome was documented as "Progressing." The care plan did not address the indwelling urinary catheter. On 1/10/17 at 12:10 pm, LN #3 was observed securing a urinary drainage bag to Resident #1's right leg. Slightly cloudy yellow urine was in the tubing and leg bag. On 1/11/17 at 10:45 am, Resident #1 said he was wearing a urinary leg bag that day. On 1/11/17 at 3:10 pm, Nursing Supervisor #1 said Resident #1 was admitted to the facility with an indwelling urinary catheter in place and the catheter was placed on 12/28/16 during Resident #1's hospitalization. Nursing Supervisor #1 reviewed Resident #1's care plan and said the indwelling urinary catheter was not included because it was not an option in the facility's computer program.	F 279	•RNs provided education related to care plan process in the EHR to be completed by 2/14/17 QAPI Integration Audit of plan of care of residents with indwelling urinary catheters to be completed weekly x 4 weeks, and then every other week for 3 months. The audit will be completed by Rehabilitation Hospital Leadership. Results will be reviewed at the Quality Assurance Performance Improvement committee monthly. In addition, data will be shared with the Quality and Safety Council of St. Luke's Treasure Valley and the Quality, Safety and Service Excellence Committee of the Board.		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission	F 315		2/14/17	

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F 315	<p>Continued From page 4</p> <p>receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.</p> <p>(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure a current order was in place for an indwelling urinary catheter and that</p>	F 315	<p>The Director of Nursing is ultimately responsible for ensuring orders are in place for indwelling urinary catheter and that catheter care is consistently</p>		

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F 315	<p>Continued From page 5</p> <p>catheter care was consistently performed or provided for 1 of 1 sample residents (#1) reviewed for indwelling urinary catheter use. The failures created the potential for more than minimal harm if Resident #1's UTI worsened or a new infection developed. Findings include:</p> <p>Resident #1 was admitted to the facility on 1/5/17 with multiple diagnoses, including CHF and UTI.</p> <p>Resident #1's current facility orders, printed 1/10/17, included oral diuretics ordered on 1/6/17 with dosage and/or instruction changes made daily through 1/9/17, and daily weights ordered on 1/5/17. An order for an indwelling urinary catheter was not documented in Resident #1's current facility orders. In addition, a care plan for an indwelling urinary catheter was not found in his clinical record.</p> <p>On 1/9/17 at 1:15 pm, urinary drainage tubing was observed under Resident #1's wheelchair. Clear, pale yellow urine was in the tubing. Resident #1 said a urinary catheter was in place because of problems with his bladder and he could not urinate without it.</p> <p>On 1/10/17 at 12:10 pm, LN #3 was observed securing a urinary drainage bag to Resident #1's right leg. Slightly cloudy, yellow urine was noted in the tubing and leg bag.</p> <p>On 1/11/17 at 10:45 am, Resident #1 said the urinary catheter was still in place and he was wearing a leg bag.</p> <p>On 1/11/17 at 3:10 pm, Nursing Supervisor #1 said Resident #1 was admitted to the facility with</p>	F 315	<p>performed. Resident #1 was discharged prior to receiving the survey report. Residents with indwelling catheters were identified and medical record reviewed to ensure that an order has been received and catheter care is completed per nursing guideline.</p> <p>Plan of Correction:</p> <ul style="list-style-type: none"> •Education for existing staff to be distributed to staff via email (2/9/2017), posting in break rooms (2/9/2017), presented at staff meetings (2/9/2017 and 2/14/2017) and individual follow up education as needed. •Additionally, catheter management is being educated in Annual Competency assessment for staff in 2017. •New staff members will receive the training and competency assessment during their orientation period. •Changes in process to the Electronic Health Record that will prompt staff for completion of catheter care related items, and ensure proper documentation. (1/30/2017) <p>QAPI Integration Audits will be conducted for 4 months on the charts of residents with indwelling urinary catheters. Audit will include a chart review of 10 random catheter days per month. Audits will verify catheter care was done at required intervals as per nursing care guidelines. The audit will be</p>		

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F 315	<p>Continued From page 6</p> <p>an indwelling urinary catheter in place. Nursing Supervisor #1 found a 12/28/16 order for the urinary catheter during Resident #1's hospitalization but said he did not find a current order for the catheter.</p> <p>On 1/11/17 at 4:15 pm, Nursing Supervisor #1 said there was "no specific documentation" of catheter care for Resident #1 but he was scheduled for daily bathing and was able to perform personal hygiene.</p> <p>On 1/12/17 in the afternoon, the facility provided additional documentation, including bathing flow sheets, catheter care records, and I & O records, regarding Resident #1.</p> <p>The bathing flow sheets, dated 1/5/17 through 1/11/17, documented Resident #1 refused a shower on 1/5/17, 1/6/17 and 1/9/17.</p> <p>The catheter care records, dated 1/7/17, 1/8 17, and 1/10/17 documented catheter care was completed on those days. There were no other catheter care records.</p> <p>The I & O records, dated 1/5/17 through 1/11/17, documented Resident #1's urine was yellow, foul smelling, and concentrated on 1/5/17; yellow and foul smelling on 1/6/17; yellow, foul smelling, and concentrated on 1/7/17; tea color, foul smelling, and concentrated on 1/8/17; amber color and concentrated on 1/9/17; and yellow, foul smelling, and concentrated on 1/10/17.</p> <p>The facility failed to ensure catheter care was consistently performed or provided for Resident #1's indwelling urinary catheter. Additionally, the</p>	F 315	<p>completed by Rehabilitation Hospital Leadership and Infection Control department. Results will be reviewed at the Quality Assurance Performance Improvement Committee monthly. In addition, data will be shared with the Quality and Safety Council of St. Luke's Treasure Valley and the Quality, Safety and Service Excellence Committee of the Board.</p>		

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F 315	Continued From page 7 facility failed to verify with the physician the continued need for the indwelling urinary catheter.	F 315			
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with	F 328		2/14/17	

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F 328	<p>Continued From page 8</p> <p>physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.</p> <p>(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, resident and staff interviews, and record review, it was determined the facility failed to ensure PRN O2 orders included a starting dose or dosing range for LPM and identified the reason for titrating PRN O2. This was true for 3 of 5 sample residents (#1, #2, & #6) reviewed for specialized care. The failure created the potential for the residents to experience suboptimal benefit from their oxygen and placed them at increased risks for side effects or complications. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 1/5/17 with multiple diagnoses, including CAD, CHF and recent MI.</p>	F 328	<p>The Director of Nursing is ultimately responsible for ensuring prn oxygen orders include a starting dose and documentation identifies the reason for titration of the dose of oxygen. Residents #1, 2, and 6 were discharged prior to receiving the final survey report. Residents requiring supplemental oxygen therapy were identified and medical record reviewed to ensure order includes starting dose and documentation supports titration.</p> <p>Plan of Correction: •Staff education to be completed by</p>		

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F 328	<p>Continued From page 9</p> <p>Resident #1 was observed breathing room air during all days of the survey.</p> <p>Resident #1's Admission orders, dated 1/5/17 at 4:53 pm, documented, "Adult oxygen therapy PRN...Apply and Titrate Oxygen to achieve ordered minimum SpO2 level. 1. Allow 10 - 15 minutes for stabilization. 2. Contact RT if an increase of 2 LPM or more and/or a mask is required. 3. Discontinue oxygen if SpO2 remains above criteria and vital signs remain stable on room air for greater than 15 minutes...Keep O2 Sat equal to or greater than: 90%. Notify Provider: If patient continues to need oxygen beyond 24 hrs from procedure or surgery...If oxygen is re-initiated after being on room air for more than 4 hours...If maintaining SpO2 greater than or equal to ordered SpO2 level and requires greater than 5 LPM cannula or 35% via mask."</p> <p>Resident #1's 1/5/17 admission assessment documented shortness of breath, difficulty breathing with exertion, and O2 at 1.5 LPM.</p> <p>O2 flowsheets, dated 1/5/17 through 1/11/17, documented Resident#1's O2 was titrated up 1.0 to 1.5 LPM without explanation on 1/5/17 at 4:25 pm when the O2 saturation was 98%.</p> <p>On 1/11/17 at 2:30 pm, Nursing Supervisor #1 said the O2 order did not indicate what liter flow to begin to titrate the O2 and at what increments to increase it, if needed. Nursing Supervisor #1 said he would start at 1 LPM but that nurses would use their nursing judgement. Nursing Supervisor #1 said the O2 order was not specific regarding the starting dose for the LPM.</p>	F 328	<p>02/07/2017</p> <ul style="list-style-type: none"> •Physician education to be completed by 02/08/2017 •The order in the Electronic health record has been updated to reflect a starting rate for oxygen at 2 liters (or greater as clinical status dictates). Titrate oxygen to minimal amount required to achieve SpO2 of greater than or equal to 90%, as determined by Pre and post Heart Rate, Respiratory Rate, SpO2 and O2 flow rate. <p>QAPI Integration Audits will be conducted for 4 months on the charts of residents on oxygen. Audit will include a chart review of 10 random resident days per month. Audit will verify prn oxygen order in place with required elements and documentation supports titration. The audit will be completed by the respiratory department. Results will be reviewed at the Quality Assurance Performance Improvement Committee monthly. In addition, data will be shared with the Quality and Safety Council of St. Luke's Treasure Valley and the Quality, Safety and Service Excellence Committee of the Board.</p>		

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F 328	<p>Continued From page 10</p> <p>On 1/11/17 at 3:25 pm, LN #2 said the PRN O2 order was not complete because it did not have a starting level for O2 and he would contact the physician for clarification.</p> <p>2. Resident #2 was admitted to the facility on 12/28/16, with multiple diagnoses, including CHF and generalized weakness.</p> <p>Resident #2 was observed breathing room air with an O2 NC by the pillow on his bed during all days of the survey.</p> <p>Resident #2's current orders included "Adult oxygen therapy PRN...Apply and Titrate Oxygen to achieve ordered minimum SpO2 level. 1. Allow 10 - 15 minutes for stabilization. 2. Contact RT if an increase of 2 LPM or more and/or a mask is required. 3. Discontinue oxygen if SpO2 remains above criteria and vital signs remain stable on room air for greater than 15 minutes...Keep O2 Sat equal to or greater than: 90%. Notify Provider: If patient continues to need oxygen beyond 24 hrs from procedure or surgery...If oxygen is re-initiated after being on room air for more than 4 hours...If maintaining SpO2 greater than or equal to ordered SpO2 level and requires greater than 5 LPM cannula or 35 % via mask." The order was dated 1/3/17.</p> <p>O2 flowsheets, dated 1/1/17 through 1/11/17, documented Resident#1 was on room air when his O2 saturation was 90% on 1/8/17 at 5:00 am. At 9:05 am, the O2 saturation was 94% with "12 hours, has been using O2 at night" documented. The LPM and the reason for O2 was not documented. On 1/9/17 at 3:27 pm, the</p>	F 328			

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F 328	<p>Continued From page 11</p> <p>saturation level was 96% on room air. On 1/10/17 at 6:19 am it was 93% on 1.5 LPM and at 10:05 am the saturation level was 96% with, "12 hours, using 2L at night." The reason for the PRN O2 or the LPM (dose) was not documented. On 1/10/17 at 3:10 pm, the saturation level was 94% on room air. However, on 1/11/17 at 6:23 am and 9:00 am, the saturation was 95% on O2 at 1.5 LPM. The reason for the PRN O2 and dose (LPM) was not documented.</p> <p>On 1/11/17 at 2:30 pm, Nursing Supervisor #1 said the O2 order did not indicate what liter flow to begin to titrate the O2 and at what increments to increase it, if needed. Nursing Supervisor #1 said he would start at 1 LPM but that nurses would use their nursing judgement. Nursing Supervisor #1 said the O2 order was not specific regarding the starting dose for the LPM.</p> <p>On 1/11/17 at 3:25 pm, LN #2 said the PRN O2 order was not complete because it did not have a starting level for O2 and he would contact the physician for clarification.</p> <p>3. Resident # 6 was admitted to the facility on 1/3/17, with multiple diagnoses including shortness of breath.</p> <p>Resident #6's Admission orders, dated 1/3/17, documented, "Adult oxygen therapy PRN...Apply and Titrate Oxygen to achieve ordered minimum SpO2 level. 1. Allow 10 - 15 minutes for stabilization. 2. Contact RT if an increase of 2 LPM or more and/or a mask is required. 3. Discontinue oxygen if SpO2 remains above criteria and vital signs remain stable on room air for greater than 15 minutes...Keep O2 Sat equal</p>	F 328			

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F 328	<p>Continued From page 12</p> <p>to or greater than: 90%. Notify Provider: If patient continues to need oxygen beyond 24 hrs from procedure or surgery...If oxygen is re-initiated after being on room air for more than 4 hours...If maintaining SpO2 greater than or equal to ordered SpO2 level and requires greater than 5 LPM cannula or 35 % via mask."</p> <p>Resident #6's O2 flowsheet from 1/3/17 through 1/11/17, documented she received 1 or 2 LPM of oxygen. The O2 flowsheet, dated 1/8/17 at 8:10 am, documented Resident #6's O2 saturation rate was at 93% and was titrated from 1 LPM to 2 LPM for her comfort.</p> <p>On 1/10/17 and 1/11/17, Resident #6 was observed three times with oxygen on via NC and set at 1 LPM.</p> <p>On 1/11/17 at 8:15 am, Resident #6 said she had not received oxygen prior to her admission, but might have to continue using it after discharge due to her medical conditions.</p> <p>On 1/11/17 at 2:30 pm, Nursing Supervisor #1 said the O2 order did not indicate what liter flow to begin to titrate the O2 and at what increments to increase it, if needed. Nursing Supervisor #1 said he would start at 1 LPM but nurses would use their nursing judgement based on the resident's condition. Nursing Supervisor #1 said the O2 order should be more specific because it did not include a starting dose for the LPM.</p> <p>On 1/11/17 at 3:25 pm, LN #1 said if a PRN O2 order did not have a starting titration level or at what increments to adjust the O2, then she would call the physician to clarify the order.</p>	F 328			

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F 371 SS=F	<p>483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure food was prepared and served under sanitary conditions when staff were observed in the kitchen without facial hair restraints. This affected 7 of 7 sampled residents (#s 1-7) and had the potential to affect all residents who dined in the facility. This failure created the potential for contamination of food and exposed residents to potential disease</p>	F 371	<p>The Sr. Director is ultimately responsible for ensuring food is prepared and served under sanitary conditions. Facility residents could potentially be affected by gaps in kitchen sanitation processes.</p> <p>Plan of Correction: "Individual Corrective actions taken with the employees identified during survey as</p>	2/1/17	

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F 371	<p>Continued From page 14 causing pathogens. Findings include:</p> <p>The 2013 FDA Food Code, Chapter 2, Part 2-4, Hygiene Practices, Hair Restraints, subpart 402.11, Effectiveness, documented, "(A) Except as provided in (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food..."</p> <p>On 1/10/17 from 11:35 am to 12:05 pm, the CDM, Kitchen Manager and Cook #1 were observed throughout the kitchen without a facial hair restraint to cover their beard and/or mustache hair. The CDM had a chin goatee without a mustache, the Kitchen Manager had a full beard with a mustache, and Cook #1 had a beard goatee with a mustache. At 11:45 am Cook #1 was observed taking food temperatures without a facial hair restraint.</p> <p>On 1/10/17 at 11:50 am, the CDM said he thought facial hair could be a quarter inch long without a facial restraint and said the Kitchen Manager and Cook #1's facial hair might have been longer than that. The CDM said he would correct the concern and then retrieved a beard restraint for himself and the Kitchen Manager and Cook #1 did the same.</p> <p>On 1/10/17 at 12:02 pm, Cook #1 was observed to dish up residents' food with a facial hair restraint covering his chin, but did not cover his mustache.</p> <p>On 1/11/17 at 3:00 pm, the CDM said the facility</p>	F 371	<p>non-compliant <input type="checkbox"/> completed 1/10/17</p> <p>"Posters demonstrating proper facial hair covering posted in dietary services in 3 different locations throughout the department as an easy point of reference for employees- completed 1/10/17</p> <p>"Improved access to beard restraints by adding restraint holders to all 3 kitchen entrances-completed 1/10/17</p> <p>"HACCP guideline reviewed and educated kitchen staff- completed 1/15/17</p> <p>QAPI Integration An audit of compliance will be completed 3x per week for 4 months. The audit will be completed by Dietary leadership. Results will be reviewed at the Quality assurance performance improvement committee monthly. In addition, data will be shared with the Quality and Safety Council of St. Luke's Treasure Valley and the Quality, Safety and Service Excellence Committee of the Board.</p>		

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F 371	Continued From page 15 did not have a policy regarding facial hair but the facility had used a food safety guideline which required the facility to follow local regulatory authority regarding facial hair.	F 371			
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of	F 441		2/14/17	

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F 441	<p>Continued From page 16 infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, it was determined the facility failed to ensure 1 of 6 RNs (#1) observed providing direct care to residents, used standard handwashing</p>	F 441	<p>The Director of Nursing is ultimately responsible for ensuring staff practice standard hand washing technique. Resident #3 was monitored for infections</p>		

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F 441	<p>Continued From page 17</p> <p>technique when turning off the faucet after handwashing. The failure created the potential for infection from cross contamination for 1 of 7 sample residents (#3). Findings include:</p> <p>LN #1 was observed to use bare hand contact to turn off the faucet after handwashing 4 times on 1/10/17 at 11:30 am when performing wound care and a dressing change for Resident #3. Before touching the resident, the LN washed her hands, turned off the faucet with a bare hand then dried her hands with paper towels. The LN used the same technique 3 more times during the wound care.</p> <p>On 1/10/17 at 3:30 pm, LN #1 said she did not use a paper towel to turn off the faucet after washing her hands when she performed wound care and the dressing change for Resident #3.</p> <p>The facility's Infection Prevention, Facility-Wide policy, effective 9/30/16, documented, "Hand hygiene is the single most important control measure in the prevention of the spread of infection." Regarding hand hygiene with soap and water, the policy documented, "Use paper towels to dry hands and then to turn off faucet; discard towel."</p>	F 441	<p>through labs, micro, resident report and provider notes until 1/24/2017- all results were normal. Other residents assigned to LN#1 whom could also have been affected by improper hand hygiene, were also monitored for infections through labs, micro, resident report and provider notes until discharge.</p> <p>Plan of Correction:</p> <ul style="list-style-type: none"> •Individual education and follow up occurred with LN #1 regarding proper hand washing technique- completed 1/11/17 •Staff to be re-educated on proper technique for hand washing as per hospital policy. Education includes proper technique and demonstration of correct technique by staff- completed by 02/03/2017 •Hand hygiene single point lesson and posters will be hung up by sinks on the unit to be completed by 02/03/2017 <p>QAPI Integration Audits will be completed on nursing staff. Ten audits per week for 4 weeks: every week of February. Twenty audits per month for 3 months: March, April and May. The audit will be completed by the Infection Prevention department. Results will be reviewed at the Quality assurance performance improvement committee monthly. In addition, data will be shared</p>		

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

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F 441	Continued From page 18	F 441	with the Quality and Safety Council of St. Luke's Treasure Valley and the Quality, Safety and Service Excellence Committee of the Board.		