IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSS BARRON – Director

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3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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August 5, 2017

Michael Blauer, Administrator
St Luke's Elmore Long Term Care
Po Box 1270
Mountain Home, ID 83647-1270

Provider #: 135006

Dear Mr. Blauer:

On **July 27, 2017**, a survey was conducted at St Luke's Elmore Long Term Care 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 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. 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 **August 15, 2017**. Failure to submit an acceptable PoC by **August 15, 2017**, may result in the imposition of penalties by **September 7, 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 <u>in column (X5)</u>.

  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 **August 31, 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 **October 25, 2017**. A change in the seriousness of the deficiencies on **September 10, 2017**, may result in

a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 25, 2017** includes the following:

Denial of payment for new admissions effective **October 25, 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 **January 23, 2018**, 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 **October 25, 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:

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 **August 15, 2017**. If your request for informal dispute resolution is received after **August 15, 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

ls/dr
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135006		07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S ELMORE LONG TERM CARE	895 NORTH 6TH EAST MOUNTAIN HOME, ID 83647

(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 7/24/17 through 7/27/17. The surveyors conducting the survey were: Edith Cecil, RN, Team Coordinator Bradley Perry, LSW Survey Abbreviations: ADL = Activities of Daily Living CNA = Certified Nurse Assistant DNS = Director of Nursing Services LFSW = Lead Food Service Worker MDS = Minimum Data Set mg/dl = Milligram/deciliter	F 000		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.	F 280		8/31/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/11/2017

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 280	Continued From page 1 (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 280		

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F 280	Continued From page 2 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, it was determined the facility failed to ensure a resident's care plan was revised to reflect current needs. This was true for 1 of 7 (#4) sampled residents and had the potential for harm if residents did not receive appropriate incontinence care and interventions due to lack of direction on the care plan. Findings include: Resident #4 was readmitted to the facility on 10/1/16 with multiple diagnoses, including urinary obstruction. Resident #4's physician order, dated 9/29/16, documented an order for a condom catheter.	F 280	The Director of Nursing (DNS) is ultimately responsible for ensuring care plans are updated and revised to reflect residents□ current status and needs. Plan of Correction Resident #4□s care plan was reviewed and updated to reflect current status. Resident #4□s Epic flow sheet was revised to include External Catheter Care monitoring. Residents who reside in this facility that have an incontinent care plan have the potential to be impacted by the indicated deficiency. A review of incontinent care	

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F 280	Continued From page 3 Resident #4's current bladder continence care plan, dated 6/12/17, documented an intervention, "Condom catheter on at all times." Resident #4's quarterly Minimum Data Set assessment, dated 6/28/17, documented the resident was cognitively moderately impaired, required extensive two-person assistance with toileting, was incontinent of bowel and bladder, and had an external catheter. Resident #4's progress notes, dated 6/30/17, documented a small area of the skin of the meatus was missing from Resident #5's penis, the physician was notified, and ordered barrier cream to the affected area. Progress notes, dated 7/7/17, documented the resident's penis had healed and no new issues were noted and "we will continue to keep the condom catheters off at this time." Resident #4's July 2017 active orders documented an order for a condom catheter. On 7/25/17 at 12:55 pm, Resident #4 was observed with an absorbent incontinent pad beneath him and the resident said there was also a pad covering the top of his peri area. He said he no longer used the condom catheter and did not like to wear incontinent briefs when in bed. On 7/24/17 at 3:00 pm, CNA #5 (Certified Nurse Assistant) said Resident #4 was incontinent of bowel and bladder and used incontinent pads while in bed because he did not like to wear incontinent briefs and the pads were checked every two hours and changed if they were wet or	F 280	plans for residents who reside in this facility was conducted to validate that the documentation reflects current resident needs and status. Variations that were identified were corrected. Long term care staff were educated on External Catheter Care continual monitoring flow sheet. Long term care leadership will review incontinent care plans at the daily stand up meeting conducted Monday-Friday. QAPI Integration Audits of incontinent care plans to be conducted by DNS or designee to ensure proper care planning and documentation. Audits to be conducted weekly x 4 weeks, then monthly x 2 months or until sustained compliance. Audit data will be reviewed at LTC Quality Safety Council meeting monthly. In addition audit data will be shared with the Quality and Safety Committee of St. Luke□s Elmore and the Quality, Safety, and Services Excellence Committee of the Board.	

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F 280	Continued From page 4 soiled. On 7/25/17 at 1:55 pm, CNA #6 said Resident #4 had used a condom catheter in the past, but had not used a catheter for a"month or two." She said the resident used incontinent pads under him and one on top of his peri area which were checked every two hours and changed if they were wet or soiled. On 7/25/17 at 2:20 pm, LPN #1 said Resident #4 did not use a condom catheter and was incontinent of bladder. On 7/26/17 at 1:50 pm, the DNS (Director of Nursing Services) said Resident #4 was incontinent of bowel and bladder and staff were to check and change the resident's incontinent pads while in bed. She said the bladder continent care plan was not updated when the resident's catheter was discontinued and it did not direct staff regarding the resident's incontinence care needs.	F 280		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, it was determined the facility failed to ensure physician orders were	F 281	The Director of Nursing (DNS) is ultimately responsible for ensuring that physician orders are discontinued based	7/31/17

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F 281	Continued From page 5 discontinued based on a resident's change of condition. This was true for 1 of 7 sampled residents (#4) and had the potential for harm if residents received inappropriate incontinent care. Findings include: Resident #4 was readmitted to the facility on 10/1/16 with multiple diagnoses, including urinary obstruction. Resident #4's physician order, dated 9/29/16, documented an order for a condom catheter. Resident #4's current bladder continence care plan, dated 6/12/17, documented an intervention, "Condom catheter on at all times." Resident #4's quarterly Minimum Data Set assessment, dated 6/28/17, documented the resident was incontinent of bowel and bladder, and had an external catheter. Resident #4's nurse progress notes, dated 6/30/17, documented a small area of the skin of the meatus was missing from Resident #5's penis, the physician was notified and the resident received a barrier cream to the affected area. Nurse progress notes, dated 7/7/17, documented the resident's penis had healed with no new issues noted and the nurse documented, "we will continue to keep the condom catheters off at this time." Resident #4's active physicians orders and treatment administration record from 7/1/17 to 7/27/17, documented a 9/29/16 physician order for a condom catheter.	F 281	on a resident□s change of condition. Plan of Correction Resident #4□s physician orders were reviewed and updated to reflect current status with a PRN condom catheter order. Current residents who reside in this facility and have catheters have the potential to be impacted by the indicated deficiency. A review of physician orders for residents with catheters who reside in this facility was conducted to validate that the physician order reflects current resident needs and status. Variations that were identified were corrected. Long term care leadership will review catheter orders and care plans at the daily stand up meeting conducted Monday-Friday. QAPI Integration Catheter audits to be conducted by DNS or designee to ensure proper physician orders and documentation. Audits to be conducted weekly x 4 weeks, then monthly x 2 months or until sustained compliance. Audit data will be reviewed at LTC Quality Safety Council meeting monthly. In addition audit data will be shared with the Quality and Safety Committee of St. Luke□s Elmore and the Quality, Safety, and Services Excellence Committee of the Board.	

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F 281	Continued From page 6 On 7/25/17 at 12:55 pm, Resident #4 said he no longer used the condom catheter and did not like to wear incontinent briefs when in bed. On 7/24/17 at 3:00 pm, CNA #5 (Certified Nurse Assistant) said Resident #4 was incontinent of bowel and bladder and used incontinent pads while in bed because he did not like to wear incontinent briefs. On 7/25/17 at 1:55 pm, CNA #6 said Resident #4 had used a condom catheter in the past, but had not used a catheter for a month or two. On 7/25/17 at 2:20 pm, LPN #1 said Resident #4 did not use a condom catheter. On 7/26/17 at 1:50 pm, the DNS (Director of Nursing Services) said the condom catheter had been a physician's order and facility staff should have obtained a physician's order when the catheter use was discontinued due to the skin issue.	F 281		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that	F 309		8/31/17

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F 309	Continued From page 7 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure physician orders provided specific direction for residents with diabetes and ileostomy care. This was true for 1 of 7 residents (#2) reviewed for physician orders. The physician orders for Resident #2 did not provide parameters of when to notify the physician of hypo/hyperglycemic episodes. This deficient practice had the potential for harm if Resident #2 experienced high or low blood glucose levels. Findings include: 1. Resident #2 was admitted to the facility on	F 309	The Director of Nursing (DNS) is ultimately responsible for ensuring physician orders provided specific direction for residents with diabetes and ileostomy care. Plan of Correction Resident #2□s orders were immediately updated while surveyors were onsite to include Notify MD parameters on 7/26/17. Residents who reside in this facility and are receiving insulin have the potential to	

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F 309	Continued From page 8 7/12/17 with diagnoses that included insulin dependent diabetes mellitus. Resident #2's Physician Orders dated July 2017, documented diabetic management as follows: *Blood glucose testing 30 minutes before meals and at bedtime * Lantus insulin, 50 units each morning * HumaLog insulin based on the pre-meal blood glucose results: Less than or equal to 150 mg/dL[milligrams per deciliter] = no insulin 151-200 mg/dL give 2 units 201-250 mg/dL give 4 units 251-300 mg/dL give 6 units 301-350 mg/dL give 8 units Greater than 350 mg/dL give 10 units Resident #2's orders also included the following: *Glucagon injection 1 mg intramuscular every 15 minutes as needed for low blood sugar. The Physician orders for Resident #2 did not direct staff to notify physician for hyperglycemic or hypoglycemic episodes or the range for notification if needed. According to the American Diabetes Association, Standards of Medical Care in Diabetes - 2016, from the Diabetes Care Journal, Volume 39 Supplement 1, documented older adults with diabetes in a long term care (LTC) facility were at higher risk of experiencing hypoglycemic episodes, and providers should be called "immediately" in case of hypoglycemic episodes or when BG levels were less than 70 mg/dl. A position statement from the American Diabetes	F 309	be impacted by the indicated deficiency. A review for residents on insulin who reside in this facility was conducted to validate that the physician order included notification parameters. Variations that were identified were corrected. Education of Medical Staff to ensure insulin orders contain parameters to notify physician for hyperglycemic or hypoglycemic episodes and the range for notification if needed. Resident # 6□s orders were updated to include ileostomy care. Long term care leadership will review ostomy orders and care plans at the daily stand up meeting conducted Monday-Friday. QAPI Integration Audits of insulin orders and ostomy care to be conducted by DNS or designee to ensure proper care planning and documentation. Audits to be conducted weekly x 4 weeks, then monthly x 2 months or until sustained compliance. Audit data will be reviewed at LTC Quality Safety Council meeting monthly. In addition audit data will be shared with the Quality and Safety Committee of St. Luke□s Elmore and the Quality, Safety, and Services Excellence Committee of the Board.	

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F 309	Continued From page 9 Association documented LTC facilities should increase the frequency of glucose monitoring, call the practitioner, and confirm high glucose values by laboratory testing. These steps were to be completed if residents experienced BG's greater than 300 during all or part of 2 consecutive days. (Munshi, M. N., Florez, H., Huang, E. S., et al. "Management of Diabetes in Long-term Care and Skilled Nursing Facilities: A Position Statement of the American Diabetes Association." Diabetes Care, vol. 39, Feb. 2016, pp. 308-318.) Resident #2's medical record, dated July 2017, did not document blood glucose levels lower than 70 mg/dL or greater than 400 mg/dL. On 7/25/17 at 10:30 am, Resident #2 stated the facility was doing a great job managing his diabetes. Resident #2 stated his "blood sugars have been good." On 7/26/17 at 2:10 pm, the facility provided a 7-page document titled "Provider Orders." This document provided the physician multiple order choices for diabetic management and included nursing to notify provider if blood glucose is less than 70 or if greater than 400. Administration Staff #2 stated, "The physicians' have been given the Provider's Order set to use, but, they have not been utilized by the physicians. The facility will be making changes." On 7/27/17 at 8:30 am, LN #1 was asked what she would do if a resident had high or low blood glucose levels. She stated she would address the resident needs and notify the physician.	F 309		
F 332	483.45(f)(1) FREE OF MEDICATION ERROR	F 332		8/31/17

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F 332 SS=D	Continued From page 10 RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure a medication error rate less than 5 percent. This was true for 2 of 37 medications (5.4%) administered during medication pass and effected 2 of 5 residents (#9 and #10) observed during medication pass. This failed practice placed residents at risk of not receiving medications as ordered by the physician and had the potential to lessen the effectiveness of the medications administered. Findings include: 1. Resident #9 was admitted to the facility on 7/17/17 with multiple diagnoses, including gastroesophageal reflux. Resident #9's Physician Order Sheet, dated July 2017, documented the resident was to receive Protonix 40 mg (milligrams) by mouth every morning before breakfast [served at 7:45am.] On 7/25/17 at 8:25 am, LPN #1 (Licensed Practical Nurse) was observed as she administered morning medications to Resident #9, which included the medication Protonix. The resident had completed her breakfast and was sitting in the activity room. The Medication Administration Record	F 332	The Director of Nursing (DNS) is ultimately responsible for ensuring a medication error rate less than 5 percent. Plan of Correction On 7/25/2017 there was an unexpected downtime of the electronic medical record. An Information Technology (IT) debrief was conducted the same day and self-identified the need to educate staff on access to the Medication Administration Record (MAR) during down times. The facility will schedule downtime simulations with long term care staff, with an emphasis on medication administration. The simulations will include re-education for staff on downtime procedures. Additionally, the staff will be educated to give medications as ordered. Interdisciplinary review of medication administration time, including Pharmacy and physicians, to adjust medication times in order to accommodate the needs of the resident. QAPI Integration Late medication administration audits to	

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F 332	Continued From page 11 documented Resident #9 received Protonix 40 mg at 8:22 am on 7/22/17, at 8:18 am on 7/23/17, and 8:30 am on 7/24/17. 2. Resident #10 was admitted to the facility on 7/17/17 with multiple diagnoses, including gastroesophageal reflux. Resident #10's Physician Order Sheet, dated July 2017, documented the resident was to receive Protonix 40 mg by mouth every morning before breakfast. On 7/25/17 at 8:35 am, LPN #1 was observed as she administered morning medications to Resident #10, which included Protonix. The resident had completed his breakfast and was sitting in his wheelchair in activity room. On 7/26/17 at 1:25 pm, the Director of Nursing stated the delivery of Protonix should be given on the 7:00 am medication pass.	F 332	be conducted on Proton Pump Inhibitors (PPI) by DNS or designee to ensure proper care planning and documentation. Audits to be conducted weekly x 4 weeks, then monthly x 2 months or until sustained compliance. Audit data will be reviewed at LTC Quality Safety Council meeting monthly. In addition audit data will be shared with the Quality and Safety Committee of St. Luke□s Elmore and the Quality, Safety, and Services Excellence Committee of the Board.	
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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.	F 371		8/31/17

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F 371	Continued From page 12 (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (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 7 of 11 plastic coffee mugs were free of debris and 4 of 6 plastic cereal and soup bowls were free from scratches and grooves. This had the potential to affect 7 of 7 (#s 1-7) sampled residents and all residents who dined in the facility. This failure created the possibility for food-born illness if bacteria remained on unsanitary surfaces. Findings include: On 7/26/17 at 11:05 am, 7 of 11 plastic coffee mugs were observed to contain a white filmy residue inside the mugs. The Lead Food Service Worker (LFSW) said it "looked and smelled" like soap residue. The LFSW said he would have them rewashed and wiped clean. 4 of 6 plastic soup and cereal bowls were observed to have several scratches inside the bowls. The LFSW said they all had scratches and "grooves" in them and he took them out of service and said he would replace them with new bowls.	F 371	The Food and Nutrition Services Manager is ultimately responsible for ensuring dishware are free from debris, scratches and grooves to prevent the possibility of food-borne illness. Plan of Correction The identified mugs and bowls were immediately discarded. Review of dishware to ensure free of defects. The residue on the coffee mugs were evaluated and found to potentially be hard water and coffee stains. Based on assessment, re-education on appropriate cleaning tools and procedures was provided to Food & Nutrition staff. QAPI Integration	

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F 371	Continued From page 13	F 371	Weekly audits for the first month will be conducted by Food and Nutrition Services Manager or designee to assess dietary sanitation practices and equipment. The audit will ensure dishware is free from debris, scratches and grooves. After the first month, the audit will be performed monthly for three months.	
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals.	F 431		8/31/17

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F 431	Continued From page 14 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure medications were labeled in accordance to Federal and State regulations and that discontinued medications were removed from the medication cart. This was true for 2 of 17 medication bins checked for labeled and discontinued medications. This failed practice created the potential for residents to receive medications not ordered for them and to receive medication that had been discontinued. Findings include:	F 431	The Pharmacist In Charge (PIC) is ultimately responsible to ensure medications are labeled in accordance to Federal and State regulations. Plan of Correction The identified Nitrostat and Nystatin were returned to the Pharmacy and replaced with appropriately dated bottles. Multi-dose medications in the medication cart were reviewed to ensure appropriate dating and current orders.	

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F 431	Continued From page 15 On 7/25/17 at 2:00pm, a resident's medication bin had a bottle of Nitrostat 0.4 mg that did not have a pharmacy label which identified the medication, strength, expiration date, resident 's name, route of administration, appropriate instructions or precautions (such as shake well, with meals, do not crush, special storage instructions). A tube of Nystatin creme, found in the same bin, had the name of the medication and the resident's name was handwritten on a piece of paper and taped to the tube. It did not have a pharmacy label that identified the medication, strength, expiration date, resident's name, route of administration, appropriate instructions or precautions (such as shake well, with meals, do not crush, special storage instructions). The resident's medical record documented the Nystatin creme had been discontinued on 6/9/17, however, the tube remained in the resident's medication bin. On 7/25/17 at 2:00 pm, LN #1 stated a pharmacist checked the medication cart each morning and removed expired and discontinued medications from the residents' medication bins. LN #1 stated she did not know why the medications were not labeled or why the discontinued medication was not removed. LN #1 stated they should have been labeled and/or removed when discontinued. On 7/25/17 at 2:30 pm, the Director of Nursing stated pharmacy labels would be common practice. The Pharmacist stated the labels should be on the medications. The Pharmacist stated he did not know why the discontinued medication	F 431	Revision of pharmacy process to include two labels, one on the box and one on the tube/bottle, to ensure required labeling is always present. The long term care and pharmacy staff were educated on the process for duplicate labeling and removal of discontinued medication. QAPI Integration Pharmacy will audit to ensure correct labels on multi-dose medications. Audits will be conducted weekly x 4 weeks, then monthly x 2 months or until sustained compliance. This data will be reviewed at the monthly LTC Quality Safety Council meetings. In addition, audit data will be shared with the Quality and Safety Committee of St. Luke□s Elmore and Quality, Safety and Service Excellence Committee of the Board.	

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F 431	Continued From page 16 was not removed from the resident's medication bin.	F 431		
F 526 SS=D	483.70(o)(1)-(4) Hospice (o) Hospice services. (1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. (2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to	F 526		8/31/17

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F 526	Continued From page 17 any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.	F 526		

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F 526	Continued From page 18 (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.	F 526		

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F 526	Continued From page 19 (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. (3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with	F 526		

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F 526	Continued From page 20 the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. (4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest	F 526		

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F 526	Continued From page 21 practicable physical, mental, and psychosocial well-being, as required at §483.20. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident, hospice staff and facility staff interview, it was determined the facility failed to ensure coordination of care, including development of a coordinated plan of care, between the hospice provider and the facility. This was true for 3 of 3 residents (#s 5, #6, #7) sampled for hospice care. This failure had the potential for harm if the residents received inadequate care from the facility and/or hospice agency due to a lack of care coordination. Findings include: Resident #'s 5 and 7 local hospice agency contract, dated 3/6/12, documented, "The plan of care will identify which provider is responsible for performing the respective functions that have been agreed upon and included in the plan of care." Resident #6's local hospice agency contract, dated 5/13/14, documented, "...hospice and facility shall jointly develop and agree upon the hospice patient's plan of care." 1. Resident #5 was readmitted to the facility on 10/1/16 with multiple diagnoses, including Alzheimer's disease. Resident #5's physician orders, dated 5/11/17, documented an order for hospice services. Resident #5's Significant Change Minimum Data Set (MDS) assessment, dated 5/15/17, documented the resident was severely impaired,	F 526	The Director of Nursing (DNS)is ultimately responsible to ensure coordination of care, including development of a coordinated care plan, between the hospice provider and our facility. Plan of Correction Develop a process to provide hospice care under a written agreement to ensure that each resident□s written plan of care includes both the most recent hospice plan of care and a description of the services furnished by our facility to attain or maintain the resident□s highest practicable physical, mental, and psychosocial well-being as required. Develop a hospice delineation form that clearly outlines coordination of care for each individual resident and is available to staff. The long term care staff were educated on the purpose and location of the hospice delineation form. QAPI Integration Audits will be conducted by DNS or designee to ensure a delineation of care form is completed for each hospice resident. Audits will be conducted weekly x 4 weeks, then monthly x 2 months or until sustained compliance. This data will	

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F 526	Continued From page 22 required extensive assistance from staff for all cares, and received hospice services. Resident #5's current facility Comfort Care (End of Life) care plan, dated 5/18/17, documented an intervention, "[Hospice Agency] hospice to help maintain comfort for [Resident #5]." No other information regarding hospice was documented in the care plan. Resident #5's record did not contain a delineation of duties between the hospice agency and the facility. On 7/26/17 at 9:25 am, Resident #5 was observed in his bed in his room. Hospice Nurse #1 was observed in the room who said she had just finished her assessment. Hospice Nurse #1 said she or another hospice nurse came into the facility at least once a week or as needed to assess the resident and a CNA (Certified Nurse Assistant) came in twice a week to bathe the resident and provide other ADLs (Activities of Daily Living) as needed. Hospice Nurse #1 said when she or another hospice staff member came into the facility they contacted the charge nurse before and after their visits and left a note in the hospice book which was located at the nurse's station. She said the facility staff was supposed to provide all cares and the hospice only provided additional support. On 7/26/17 at 9:35 am, CNA #1 said the hospice provided the resident showers and the facility provided all other ADL cares. She said if the hospice staff were unable to provide the resident a shower, the facility staff were to provide showers for Resident #5.	F 526	be reviewed at the monthly LTC Quality Safety Council meetings. In addition, audit data will be shared with the Quality and Safety Committee of St. Luke□s Elmore and Quality, Safety and Service Excellence Committee of the Board.	

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	135006		07/27/2017

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ST LUKE'S ELMORE LONG TERM CARE	895 NORTH 6TH EAST MOUNTAIN HOME, ID 83647

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F 526	Continued From page 23 On 7/26/17 at 9:45 and 10:15 am, RN #1 said hospice provided the resident showers and the facility provided all other ADL cares. She said if the hospice staff were unable to provide the resident a shower, the facility staff were to provide showers. RN #1 said this information should be in Resident #5's facility care plan, including frequency of visits by hospice staff. She said the hospice agency care plan for hospice staff, along with notes were located in a book at the nurses station. On 7/27/17 at 2:45 pm, the DNS (Director of Nursing Services) said Resident #5's facility hospice care plan lacked direction for facility staff regarding what services the hospice provided versus what facility provided and lacked information regarding frequency of hospice visits. The DNS said there was no delineation of duties for the resident. 2. Resident #6 was admitted to the facility on 6/23/17 with multiple diagnoses, including terminal ovarian cancer. Resident #6's physician orders, dated 6/27/17, documented an order for hospice services. Resident #6's Admission MDS, dated 6/30/17, documented the resident was cognitively intact, required limited assistance of one staff member for toileting, had an ostomy (a surgical opening in the body to discharge waste) and received hospice services. Resident #6's current facility Comfort Care (End of Life) care plan, dated 6/23/17, documented an	F 526		

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F 526	Continued From page 24 intervention, "Staff will collaborate with [Hospice Agency] on end of life cares. She will be encouraged to participate in activities that she enjoys. She will be able to attend spiritual services as she wishes." No other information regarding hospice was documented in the care plan. The resident's bowel care plan, dated 6/23/17, documented how facility staff were to assist the resident with her ostomy care. Resident #6's record did not contain a delineation of duties between the hospice agency and the facility. Resident #6's ADL flow sheet, dated 7/26/17, documented a Hospice CNA assisted the resident in changing her ostomy bag and wafer. On 7/26/17 at 4:00 pm, Resident #6 was observed in her bed in her room. Hospice CNA #3 was observed to offer the resident a mug of ice water and asked the resident if she needed anything else. On 7/26/17 at 4:05 pm, Hospice CNA #3 said hospice CNA staff came to the facility for Resident #6 at least once a week and as needed and provided various ADL cares and services for the resident. On 7/27/17 at 8:50 am, Resident #6 said she had just requested for hospice to come and give her a bath. She said when she requested a bath, the hospice or facility staff would provide a bath for her. On 7/27/17 at 8:55 am, CNA #2 said the CNA who was providing showers for that day was	F 526		

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F 526	Continued From page 25 aware of the resident's request and would offer the resident a bath. CNA #2 said the facility provided all of the resident's ADL cares, including showers and hospice provided extra showers and cares. On 7/27/17 at 9:50 am, CNA #4 was observed to provide Resident #6 with a bed bath in the resident's room. On 7/27/17 at 9:55 am, LPN #1 said she had only been working in the facility for a few days. She said the resident's facility care plan should document which services the facility provided and which services the hospice provided. LPN #1 said hospice staff checked in with her when they visited the resident. On 7/27/17 at 11:05 am, CNA #3 said she had assisted Resident #6 and Hospice CNA #3 the day before with the ostomy bag change and said the hospice agency supplied the resident's ostomy supplies, which were kept in the resident's room. On 7/27/17 at 3:00 pm, the DNS said there was no delineation of duties for the resident. She said Resident #6's facility's hospice care plan lacked direction for facility staff regarding what services the hospice provided versus what facility provided, lacked information regarding frequency of hospice visits, and did not address who would provide the resident's ostomy supplies. 3. Resident # 7 admitted to the facility on 3/24/17 with the diagnoses of senile degeneration of the brain and decubitus ulcers.	F 526		

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F 526	Continued From page 26 Resident #7's physician orders, dated 3/24/17 included hospice care. Resident #7's Admission MDS assessment, dated 3/31/17, documented the resident was severely cognitively impaired, required extensive assist of 2 or more staff for bed mobility, transfers, dressing, toileting, and personal hygiene with hospice care provided. Resident #7's facility care plan, dated 3/24/17, documented comfort care for end of life care. The goal documented for Resident #7 was to be free from pain. The care plan documented the facility and hospice staff would work together to manage the Resident's end of life care. Resident #7's hospice care plan documented weekly visits from the licensed nurse and the CNA and monthly visits from the social worker. A binder was located at the nurse's station which was entitled "Hospice" contained weekly notes that documented the care provided by the hospice Licensed Nurse and CNA. On 7/27/17 at 2:45 pm, the DNS (Director of Nursing Services) said Resident #7's facility's hospice care plan lacked direction for facility staff regarding what services the hospice provided versus what facility provided and lacked information regarding frequency of hospice visits. The DNS said there was no delineation of duties for the resident.	F 526		