IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON– 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
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June 15, 2018

Nolan Hoffer, Administrator
St Luke's Rehab - Elks Sub Acute Rehab Unit
600 North Robbins Road,
Boise, ID 83702-4565
Provider #: 135114

CORRECTED LETTER

Dear Mr. Hoffer:

On **June 1, 2018**, 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.) **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 **June 25, 2018**. Failure to submit an acceptable PoC by **June 25, 2018** , may result in the imposition of additional civil monetary penalties by **July 18, 2018**.

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.

- 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*.

This agency is required to notify Centers for Medicare & Medicaid Services (CMS) Regional Office of the results of this survey. We are recommending to the CMS Regional Office that the following remedy(ies) be imposed:

Denial payment for new admission effective September 1, 2018.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your

provider agreement be terminated on **December 1, 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 and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

Your facility's noncompliance with the following:

F0700 -- S/S: F -- 483.25(n)(1)-(4) -- Bedrails

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

> The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:
>
> Residents # **#104, #109, #110, #112, #154, #155, #158, #160** as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

If you believe the deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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:

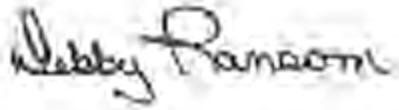
- BFS Letters (06/30/11)

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

This request must be received by **June 25, 2018** . If your request for informal dispute resolution is received after **June 25, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



Debby Ransom, RN, RHIT,Chief
Bureau of Facility Standards

dr/
Enclosures

cc: Chairman, Board of Examiners - Nursing Home Administrators

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135114		06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S REHAB - ELKS SUB ACUTE REHAB UNIT	600 NORTH ROBBINS ROAD BOISE, ID 83702

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F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility from May 29, 2018 through June 1, 2018. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Wendi Gonzales, RN Linda Kelly, RN Survey Abbreviations: CNA = Certified Nursing Assistant DON = Director of Nursing H&P = History and Physical OT = Occupational Therapy PT = Physical Therapy RN = Registered Nurse SMA = Senior Manager of Accreditation	F 000		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including	F 583		7/18/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 06/22/2018

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 583	Continued From page 1 the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, record review, resident and staff interview, it was determined the facility failed to ensure residents' privacy was maintained while video cameras were in use in residents' rooms. This was true of 1 of 8 residents (#109) sampled for privacy and had the potential to affect residents residing in 9 of 19 rooms (Room #304, #305, #306, #307, #309, #310, #311, #316, and #317) with video cameras. The facility also failed to ensure residents' private health information was protected when residents' doors and arm bracelets displayed private health information. This was true for 6 of 8 residents (#109, #112, #154, #155, #158, and #160) sampled for privacy. These failures created the potential for psychosocial harm if residents' rights to personal privacy was not honored and confidential health information was displayed to the public, which	F 583	The Director of Nursing is ultimately responsible for ensuring that all residents have the right to privacy and confidentiality. Plan of Correction: Residents #109, #112, #154, #155, #158, #160 were discharged prior to receiving the final survey report. Any resident determined to be a high fall risk could be affected by this practice. Fall Prevention program policy will be reviewed and updated to ensure compliance with privacy regulations. The facility will discontinue the use of video monitoring, fall wristbands, and placement of signs on the hallway doorframes. Alternatives utilized will include, but are not limited to use of	

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F 583	Continued From page 2 had the potential to result in a lack of self-worth for residents. Findings include: 1. The facility's Video Monitoring policy, dated 11/30/17, documented: *Video monitoring was for patients with a high fall risk or other safety issues to keep patients safe and free from harm. *The need to monitor patients was based on diagnosis and/or behaviors exhibited. *Patients or the decision maker must consent to the use of video monitoring. *An assigned staff member watched the video monitored when in use and documented observations of the patient. These observations may be used to determine the continued need for video monitoring. *Patients who consent may withdraw their consent and video monitoring would be discontinued. *To ensure dignity during patient care, the room video monitor would be switched off. A list provided by the DON on 6/1/18 at 8:40 AM, documented video cameras were in resident rooms #304, #305, #306, #307, #309, #310, #311, #316, and #317, and were able to video monitor the residents in those rooms. Resident #109 was admitted to the facility on 5/18/18 with multiple diagnoses, including avascular necrosis of the right hip (the death of bone tissue due to the lack of blood supply). Resident #109's nurse progress note, dated 5/18/18 at 7:53 PM, documented the resident was admitted to the facility at 4:00 PM and later that evening placed on video monitoring due to	F 583	sitters, increased rounding, and utilization of a communication tool not available for public viewing. Staff will be re-educated to the expectations of the fall policy and subsequent change in practice related to fall risk initiatives utilized at the facility. QAPI Integration Absence of, falls wrist bands, and door signs audits will be conducted by the clinical Leadership team monthly, for a minimum of 4 months. 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.	

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F 583	Continued From page 3 "impulsivity." Resident #109's Video Monitoring Consent forms, dated 5/18/18 at 7:35 PM and 5/22/18 at 2:00 PM, documented the resident consented to video monitoring. Resident #109's nurse progress notes, care plan, video patient monitoring forms, and fall risk assessments, dated 5/18/18 through 5/30/18, documented the resident was a high fall risk and was monitored with a video camera. The record did not document what other interventions were tried prior to the video monitor placement. On 5/29/18 at 10:39 AM and 2:46 PM and on 5/30/18 at 8:15 AM and 12:24 PM, Resident #109's room door frame contained a small yellow magnetic sign which documented, "Video in use." Resident #109 was either in his wheelchair or in the recliner in his room and a stationary video camera was attached high on the wall, opposite of the resident's bed and recliner. On 5/29/18 at 10:39 AM and on 5/30/18 at 8:15 AM, Resident #109 said he did not like the camera in his room, did not know why the camera was placed in the room, and said he was not sure "whose idea that was." He said he had a staff member in his room at night to watch him and he did not care for that either. Resident #109 said he could leave his room whenever he wanted and a staff member would appear and walk with him. He said he also left his room for some meals, but generally liked to stay in his room. On 5/29/18 at 10:47 AM, RN #4 said the video	F 583		

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F 583	Continued From page 4 was monitored from the on the second-floor nurses' station in the Rehab hospital. The skilled nursing facility is on the 3rd floor in the building. On 5/30/18 at 9:13 AM and 5/31/18 at 10:17 AM, the second floor nurses' station video monitoring screen was observed behind a V-shaped desk. The screen was obscured from passersby in the hallway. The monitor screen could be viewed if someone leaned over either side of the desk or if they went into the nurses' station through the adjacent opened hallway which connected to the back of the station. On 5/30/18 at 9:13 AM, Resident #109 was observed via the second floor video monitoring screen. He was in his wheelchair in his room reading a paper. The bed and recliner and most of the room was visible on the screen. The short hallway leading to the bathroom was not within the view of the camera. On 5/30/18 at 9:15 AM, CNA #1 was monitoring the video feed and called Resident #109's nurse when the resident moved out of camera range. CNA #1 disconnected the call and said the nurse was in the hallway talking to Resident #109 and everything was fine. CNA #1 said she would call the nurse whenever the resident moved out of view of the camera, when a staff member was not present. On 5/30/18 at 3:05 PM, CNA #2 said Resident #109 had a Personal Safety Attendant (PSA) with him at night and was video monitored during the day to make sure the resident remained safe from falling. CNA #2 said when the resident went 'out of view of the video' then the CNA who	F 583		

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F 583	Continued From page 5 monitored the camera would phone the nurse and the nurse or another staff member would see what the resident needed and would also walk along the hallways with the resident if he wanted to do that. On 5/30/18 at 3:41 PM, RN #2 said the video monitor was in place due to Resident #109's "impulsivity" and he had a PSA at night. RN #2 said the resident had been not been impulsive on that day. On 5/30/17 at 5:07 PM, the hallway overhead speaker said, "Safe room [Resident #109's room number]." RN #2 then went into Resident #109's room and found the resident standing and closing his room blinds. RN #2 politely asked the resident to sit back down in his wheelchair, so she could close the blinds for him. At 5:14 PM, RN #2 was back in the room. RN #2 stepped out of the room and said she had received a phone call from the CNA who monitored the camera and was told that Resident #109 was out of view of the camera. RN #2 said she found the resident in the entry way into the room. On 5/30/18 at 5:19 PM, Resident #109 opened the door leading to the main hallway and sat in his wheelchair looking out into the hallway. Two CNAs walked by without noticing the resident was out of the camera's view. After two minutes, the resident wheeled himself back into his room and the door was left halfway open. There was no announcement on the overhead speaker. On 5/31/18 at 10:17 AM, CNA #3 was monitoring the video feed and said Resident #109 was observed to be impulsive and would stand up	F 583		

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F 583	Continued From page 6 and walk around his room without assistance. CNA #3 said when this happened, he would call the nurse or announce "safe" into the intercom overhead speakers. He said the videos were not recorded, but the observations of the residents were documented. CNA #3 said when staff were doing personal cares then the staff in the room would turn off the camera with a switch in the room. CNA #3 said if a resident chose to be in the room in a state of undress, then he would call the nurse. On 5/31/18 at 11:08 AM, Resident #109's room had a switch that resembled a light switch which turned the camera on and off. The switch was behind the door into the room and was covered on 3 of 4 sides with a plastic barrier. On 5/31/18 at 11:26 AM, the SMA said, with the DON present, that Resident #109 was placed on video monitoring due to impulsivity. The SMA said the videos were not recorded and were only viewed by a CNA in a private area. The SMA said the video gave staff an early warning system to prevent falls, but it did not stop residents from falling. The SMA said about 50% of the resident population had had brain injuries or strokes, which was part of the reason the video monitors were in place. The DON said Resident #109 was a high fall risk, had not fallen in the facility, and did not have a brain injury. The SMA said if residents were observed on the video monitor in a state of undress, staff would encourage the resident to put some clothes on or explore other options. The DON said the facility wanted to make sure that all the residents stayed safe and use of video monitors helped with that.	F 583		

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F 583	Continued From page 7 On 6/1/18 at 8:40 AM, the DON said 9 rooms (#304, #305, #306, #307, #309, #310, #311, #316, and #317) contained video cameras. On 6/1/18 at 9:21 AM, the Administrator said, with the DON present, the video cameras did not record and were there for residents' safety. The Administrator said balancing safety versus residents' privacy, was a "tough one." The DON said Resident #109 knew he was being video monitored. The DON said the video monitor would be taken off if the resident told staff he no longer wanted it. The DON said she was not aware that Resident #109 did not like the camera in his room. The DON said staff had not followed-up with the resident about the continued use of the video camera. 2. The facility's Fall Prevention policy, dated 4/30/18, documented patients who were a high fall risk could have several precautions implemented, which included a yellow sign outside the door and a yellow arm band. a. Resident #112 was admitted to the facility on 5/17/18 with multiple diagnoses, including a history of falls. Resident #112's current care plan documented fall interventions directed staff to place a yellow arm band on the resident and to post a fall risk sign. On 5/29/18 at 11:15 AM and 5/31/18 at 12:33 PM, Resident #112's room door frame contained a small yellow magnetic sign which documented, "Fall Risk" in black letters. Resident #112's left wrist had a yellow plastic bracelet which	F 583		

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F 583	Continued From page 8 documented "Fall Risk" in black letters. On 5/29/18 at 12:33 PM, Resident #112 said about the bracelet, "How else are they (staff) suppose to know that I might fall." b. Resident #109 was admitted to the facility on 5/18/18 with multiple diagnoses, including avascular necrosis of the right hip. Resident #109's current care plan documented fall interventions directed staff to place a yellow arm band on the resident and to post a fall risk sign. On 5/29/18 at 10:39 AM and on 5/30/18 at 8:15 AM, 12:24 PM and 5:19 PM, Resident #109's room door frame contained a small yellow magnetic sign which documented, "Fall Risk" in black letters. Resident #109's left wrist had a yellow plastic bracelet which documented "Fall Risk" in black letters. On 6/1/18 at 8:41 AM, the DON said the "Fall Risk" bracelets were a visual reminder to alert the staff to know which residents were at risk to fall. On 6/1/18 at 9:21 AM, the Administrator said the "Fall Risk" signs and bracelets were to alert staff and visitors that those residents were at a high risk to fall. c. Resident #155 was admitted to the facility on 5/23/18, with a closed fracture of left proximal humerus (shoulder fracture) and multiple diagnoses, including uncontrolled diabetes mellitus type 2, stroke, and chronic kidney	F 583		

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F 583	Continued From page 9 disease. Resident #155's current care plan documented fall interventions which directed staff to post a fall risk sign on the outside of the resident's door. Resident #155 was observed on 5/23/18 through 6/1/18 with a yellow "Fall Risk" armband on the resident's right wrist and a yellow "Fall Risk" sign posted on the outside of the resident's door d. Resident #158 was admitted to the facility on 5/24/18, with colostomy and multiple diagnoses, including stroke with residual hemiparesis (one-sided paralysis), dysphagia (difficulty swallowing), dementia and osteoporosis. Resident #158's current care plan documented fall interventions which directed staff to place a yellow arm band on the resident and to post a fall risk sign on the outside of the resident's door. Resident #158 was observed on 5/24/18 through 6/1/18 with a yellow "Fall Risk" armband on the resident's left wrist and a yellow "Fall Risk" sign posted on the outside of the resident's door. e. Resident #154 was admitted to the facility on 5/25/18, with an ulcer and right lower extremity revascularization (circulation restoration) and multiple diagnoses, including Parkinson's disease, and chronic kidney disease. Resident #154's current care plan documented fall interventions which directed staff to place a yellow arm band on the resident and to post a fall risk sign on the outside of the resident's door.	F 583		

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F 583	Continued From page 10 Resident #154 was observed on 5/25/18 through 6/1/18 with a yellow "Fall Risk" armband on the resident's left wrist and a yellow "Fall Risk" sign posted on the outside of the resident's room. f. Resident #160 was admitted to the facility on 5/23/18, with multiple diagnoses, including diabetes mellitus, heart failure, obesity, and acute renal failure with chronic kidney disease. Resident #160's current care plan documented fall interventions which directed staff to place a yellow arm band on the resident and to post a fall risk sign on the outside of the resident's door. Resident #160 was observed on 5/23/18 through 6/1/18 with a yellow "Fall Risk" armband on the resident's right wrist and a yellow "Fall Risk" sign posted on the outside of the resident's room.	F 583		
F 700 SS=F	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 700		7/18/18

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F 700	Continued From page 11 §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to ensure that prior to the placement of bed side rails, alternatives to bed side rails were attempted, individual residents were thoroughly assessed for the risk of entrapment, and a consent was in place. This was true for 19 of 19 beds that affected all residents in the facility and for 8 of 8 residents (#104, #109, #110, #112, #154, #155, #158, #160) sampled for bed side rails use and created the potential for harm from entrapment or injury related to the use of bed side rails. Findings include: The facility's Restraints Policy, dated 3/31/17, directed staff to provide bed side rails for the resident, as an exception to a physical restraint. The policy stated, "Patients in Long Term Care units will have a signed consent for restraint use on file." 1. Resident #155 was admitted to the facility on 5/23/18, with a closed fracture of left proximal humerus (shoulder fracture) and multiple diagnoses, including stroke and chronic kidney disease. Resident #155's clinical record did not include safety assessments, consents or what	F 700	The Director of Nursing is ultimately responsible for ensuring that prior to the placement of bed side rails, alternatives to bed side rails are attempted, individual residents are thoroughly assessed for the risk of entrapment, and a consent is in place. Plan of Correction: Residents #104, #109, #110, #112, #154, #155, #158, #160 were discharged prior to receiving the final survey report. Current residents have the potential to be affected by this practice. A plan of action is in place for current residents that includes, bed evaluation, side rail assessment, side rail consent, provision of alternatives, initiated prior to resident's use of side rails Facility beds will be modified to accommodate residents who do not wish to have side rails. The side rails on the lower section of the beds will be removed. The upper rails will be provided with an option to lock the rails into the lower position. This will allow us to utilize the rails as enabling devices (as appropriate/assessed) or to lock them in the lower position if rails are not	

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F 700	Continued From page 12 alternatives were provided prior to the placement of bed side rails. Resident #155's nurse flowsheets documented the number of side rails in a raised position from 5/23/18 to 5/30/18. The flowsheets documented under the Side Rails/Bed Safety section the number of bed side rails raised. On 5/29/18 at 9:50 AM, Resident #155 was observed lying in bed with 2 of 4 side rails raised on the bed. On 5/29/18 at 2:04 PM, Resident #155 was observed lying in bed with 1 of 4 side rails raised on the bed. On 05/30/18 at 8:45 AM, Resident #155 was observed sitting on the edge of the bed eating breakfast, with 1 of 4 side rails raised on the bed. On 5/30/18 at 8:59 AM, Resident #155 was observed lying in bed watching TV. She stated she used the bed rails to move and get up in bed. She said she also used the bed positioning controls located in the bed side rails. She indicated the facility did discuss the use of the side rails with her. 2. Resident #158 was admitted to the facility on 5/24/18, with a colostomy and multiple diagnoses, including stroke with residual paralysis, dysphagia (difficulty swallowing), and dementia. Resident #158's clinical record did not include safety assessments, consents or what alternatives were provided prior to the placement	F 700	appropriate. Nursing will be required to contact Building services in the event that any of the upper side rails need to be unlocked. In the event that an air mattress is necessary, the mattress and the bed will be rented in tandem and assessed prior to resident placement with consent obtained. With regards to controls, the only controls built into the bed are the functions that raise, lower and tilt the head and foot of the bed. The call light and television controls are separate, with independent pendants. 10 Hill Rom beds have been identified with bed control pendant functions, separate from the side rails and those beds are in the process of being concentrated to the sub-acute unit. Additionally, the manufacturer of the Stryker beds has been contacted and we have identified a means to retrofit pendants controls that will also allow the beds to function independent of the side rails. These have been ordered and will arrive before our date of compliance. Concentrating the Hill Rom beds and retrofitting the Stryker beds should alleviate the concern around the controls. Residents will be provided the alternative of no side rails. If residents desire to utilize side rails to assist with mobility, consent for side rail will be obtained only after a thorough assessment has been completed, risks and benefits addressed with the resident and resident fully	

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F 700	Continued From page 13 of bed side rails. Resident #158's nurse flowsheets documented the number of side rails in a raised position from 5/24/18 to 5/30/18. The flowsheets documented under the Side Rails/Bed Safety section the number of bed side rails raised. On 5/29/18 at 10:15 AM, Resident #158 was observed sitting in his wheelchair eating breakfast. The bed had 2 of 4 side rails raised. On 5/29/18 at 2:08 PM, Resident #158 was observed lying in bed with 1 of 4 side rails raised on the bed. On 5/30/18 at 8:31 AM, Resident #158 was observed sitting in wheelchair eating breakfast. The bed had 1 of 4 side rails raised. Resident #158 stated he used the rails to move in bed and did not care if the rails were up or down. He stated he was able to move the rails up and down if he needed to. Resident #158 said the facility did not talk with him about use of the rails. 3. Resident #154 was admitted to the facility on 5/25/18, with an ulcer and right lower extremity revascularization (circulatory restoration) and multiple diagnoses, including Parkinson's disease, arthritis, and chronic kidney disease. Resident #154's clinical record did not include safety assessments, consents or what alternatives were provided prior to the placement of bed side rails. Resident #154's nurse flowsheets documented the number of side rails in a raised position from	F 700	informed. Clinical nursing staff to be educated on the expectations of completing requirements (clinical portion of bed evaluation, side rail assessment, consent and care plan). Staff education to be provided in a variety of ways including but not limited to email, review at daily huddle, review at staff meeting, posting within the unit. QAPI Integration Bed evaluation, side rail, consent and care plan audits will be completed on a weekly basis for the first month post implementation, then biweekly for another month and then monthly for the next 2 months to be concluded in October, 2018 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.	

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F 700	Continued From page 14 5/25/18 to 5/30/18. The flowsheets documented under the Side Rails/Bed Safety section the number of bed side rails raised. On 5/29/18 at 9:40 AM, Resident #154 was observed receiving wound care on left foot by wound care nurse. Resident was lying on the bed with 2 of 4 bed side rails raised. On 5/30/18 at 4:23 PM, Resident #154 was observed lying in bed with 2 of 4 bed side rails raised. On 5/31/18 at 8:43 AM, Resident #154 was observed lying in bed with 2 of 4 bed side rails raised. On 5/30/18 at 12:04 PM, Resident #154 stated he did not feel the side rails were keeping him from getting up and out of bed. He said he used the rails to move around in the bed and to get up in the bed. He said he used the bed positioning controls located in the the upper side rails to move the bed up and down. Resident #154 said he was not able to move the rails up or down and asked staff to assist him when he wanted the rail down to get out of the bed. He stated the staff had reviewed the use of the side rails with him. 4. Resident #160 was admitted to the facility on 5/23/18, with multiple diagnoses, including diabetes mellitus , heart failure, and acute renal failure with chronic kidney disease. Resident #160's clinical record did not include safety assessments, consents or what alternatives were provided prior to the placement of bed side rails.	F 700		

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F 700	Continued From page 15 Resident #160's nurse flowsheets documented the number of side rails in a raised position from 5/23/18 to 5/30/18. The flowsheets documented under the Side Rails/Bed Safety section the number of bed side rails raised. On 5/29/18 at 2:15 PM, Resident #160 was observed sitting on a chair next to the bed with 2 of 4 bed side rails raised. On 5/31/18 at 9:09 AM, Resident #160 was observed lying in bed with 4 of 4 bed side rails raised. On 6/1/18 at 10:15 AM, Resident #180 was observed lying in bed with 2 of 4 bed side rails raised. On 5/30/18 at 8:46 AM, Resident #160 was observed lying in bed with 2 of 4 bed side rails raised. She stated staff did ask her about the side rails and she had a choice of whether the rails were in a raised or lowered position. 5. Resident #104 was admitted to the facility on 5/22/18 with multiple diagnoses, including morbid obesity. Resident #104's clinical record did not include safety assessments, consents or what alternatives were tried prior to the placement of bed side rails. From 5/22/18 to 5/30/18, Resident #104's nurse flowsheets documented 2 of 4 side rails were in the raised position 2 times and 4 of 4 side rails were in the raised position 24 times.	F 700		

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F 700	Continued From page 16 On 5/29/18 at 12:14 PM, Resident #104 was in a bariatric sized airbed with 2 upper and 2 middle 1/4 bed side rails in the raised position. The bed controls were in the upper 2 side rails. At 2:56 PM, the resident transferred from his wheelchair into his bed with 3 of 4 bed side rails in the raised position. A therapist was assisting the resident into the bed where the fourth bed side rail attached to the bed was in the lowered position. On 5/30/18 at 4:18 PM, the resident was in his bed with 4 bed side rails in the raised position. On 5/30/18 at 4:25 PM, RN #1 said 4 of the bed side rails were raised upright on Resident #104's bed. 6. Resident #110 was admitted to the facility on 5/22/18 with multiple diagnoses, including congestive heart failure. Resident #110's clinical record did not include safety assessments, consents or what alternatives were tried prior to the placement of bed side rails. From 5/23/18 to 5/31/18, Resident #110's nurse flowsheets documented 2 of 4 side rails were in the raised position 32 times. On 5/29/18 at 12:28 PM and 5/30/18 at 4:20 PM, Resident #110 was in his bed with 2 upper 1/4 bed side rails in the raised position. The bed controls were in the upper side rails. Two lower 1/4 bed side rails were in the lowered position. On 5/29/18 at 12:30 PM, Resident #110 said he used the bed side rails to help turn himself in the	F 700		

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F 700	Continued From page 17 bed. 7. Resident #112 was admitted to the facility on 5/17/18 with multiple diagnoses, including fracture of the left superior and inferior pubic rami (pubic bone). Resident #112's clinical record did not include safety assessments, consents or what alternatives were tried prior to the placement of bed side rails. From 5/17/18 to 5/30/18, Resident #112's nurse flowsheets documented 2 of 4 side rails were in the raised position 4 times and 4 of 4 side rails were in the raised position 54 times. On 5/29/18 at 11:15 AM, Resident #112 was in his bed with 2 upper 1/4 bed side rails in the raised position with bed controls and 2 lower 1/4 bed side rails in the raised position. On 5/30/18 at 4:15 PM, the resident was in bed with 2 upper 1/4 side rails and the lower right 1/4 bed rail in the raised position. The lower left had side rail was in the lowered position. On 5/29/18 at 11:15 AM and 5/30/18 at 4:15 PM, Resident #112 said the side rails kept the air mattress in place and she used them to get in and out of bed. 8. Resident #109 was admitted to the facility on 5/18/18 with multiple diagnoses, including avascular necrosis of the right hip (the death of bone tissue due to the lack of blood supply). Resident #109's clinical record did not include safety assessments, consents or what	F 700		

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F 700	Continued From page 18 alternatives were tried prior to the placement of bed side rails. On 5/30/17 at 3:47 PM and 4:24 PM, Resident #109 was in his room in his wheelchair. Two upper 1/4 bed side rails were in the raised position on the resident's bed. The bed controls were in the upper side rails. Two attached lower 1/4 bed side rails were in the lowered position. 9. On 5/30/18 from 4:15 PM to 4:30 PM, 19 of 19 beds (Rooms 300 to 319) were observed in the facility. All the beds had 4 1/4 bed side rails either in the raised or lowered position and the rooms were either occupied or unoccupied. (Residents were admitted and discharged frequently due to the resident population.) On 5/30/18 at 3:41 PM, RN #1 said 2 of 4 bed side rails in the raised position was "our default," unless a resident used an airbed and those would have 4 bed side rails up. RN #1 said the side rail assessment documented the number of side rails that were in use at that time. On 5/30/18 at 3:44 PM, RN #2 said the bed side rail assessment was completed each shift. RN #2 said the assessment consisted of making sure the side rails were in the raised position, documented how many were raised, and made sure the rails were not broken. On 5/30/18 at 2:25 PM and 4:40 PM, the DON said the facility's bed and call light controls were built into the bed side rails and were provided to every resident in the facility when they were admitted. She said there were no safety assessments completed for residents' bed side	F 700		

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F 700	Continued From page 19 rails and the side rail assessments documented how many side rails were in the raised position. The DON said the side rails were considered a mobility device and not a restraint, so they were not assessed for restraints. On 5/30/18 at 4:40 PM, the Administrator said he would expect nursing to make sure bed side rails were safe and individualized for residents. On 5/31/18 at 8:40 AM, the Manager of Building Services (MBS) and two other building services staff members were observed going room to room in the facility. At 8:45 AM, the MBS said he and the other two staff members were in the process of conducting bed side rail safety assessments to check for gaps and bed integrity. The MBS said the form they were using, which documented entrapment risks, was just provided to the MBS from the Administrator on the evening of 5/30/18. On 5/31/18 at 9:25 AM, the Administrator, with the Vice-President of Quality Operations (VPQO) present, said the facility had not offered alternatives prior to placing residents in a bed with side rails because all the beds had electronic bed controls built into the side rails. The Administrator said there was no way to operate the bed controls with a remote control, due to the "older" age of the beds. The VPQO said she did not think the bed side rails could be removed because that would dismantle the whole bed and would make the beds inoperable. The Administrator said there were no consents for the side rails and staff had just received verbal consents by all the residents in the facility the evening of 5/30/18. The Administrator said the	F 700		

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F 700	Continued From page 20 staff had not been completing bed side rail safety assessments on any of the residents in the facility. He said he had just discovered a side rail assessment, which included a safety assessment, the previous day and the assessment would be implemented that day. The Administrator said the facility had just created a side rail evaluation for entrapment on the evening of 5/30/18 and it was given to the MBS to inspect all the beds that day.	F 700		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the	F 838		7/18/18

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F 838	Continued From page 21 resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the facility assessment identified resources and	F 838	The administrator is ultimately responsible for ensuring that the facility assessment identified resources and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135114		06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 838	Continued From page 22 equipment to provide person centered care and services required by residents. This was true for 8 of 8 (#104, #109, #110, #112, #154, #155, #158 and #160) sampled residents and all other residents residing in the facility. This created the potential for harm if the facility did not have the resources to provide the necessary care and services the residents required. Findings include: The Facility's Assessment, dated February 2018, documented: *Part 2. Identify hazards and risks for patients. *Part 3. Replacement of old or outdated equipment was done with the inventory management process, preventive maintenance process and identified needs based on the population served. On 5/30/18 at 2:25 PM and 4:40 PM, the DON said the facility's bed and call light controls were built into the bed side rails and were provided to every resident in the facility when they were admitted. On 5/31/18 at 9:25 AM, the Administrator, with the Vice-President of Quality Operations (VPQO) present, said the facility had not offered alternatives prior to placing residents in a bed with side rails because all the beds had electronic bed controls built into the side rails. The Administrator said there was no way to operate the bed controls with a remote control, due to the "older" age of the beds. The VPQO said she did not think the bed side rails could be removed because that would dismantle the whole bed and would make the beds inoperable. This was true for 8 of 8 (#104, #109, #110, #112,	F 838	equipment to provide person centered care and services required by residents. Plan of Correction: Residents #104, #109, #110, #112, #154, #155, #158, and #160 were discharged prior to receiving the final survey report. Current residents have the potential to be affected by this process. The facility conducts annual preventative maintenance on all beds, according to manufacturer's specifications. Additionally, the beds are evaluated for proper operation and function. This practice will continue. Beds assigned to current residents have been evaluated utilizing the FDA guidelines for entrapment as well as manufacturer's instructions for use. The beds without detachable controls housed in the side rails have been retrofitted with a detachable pendant, allowing the bed functions to operable separate from the side rails. This allows resident independence for bed function, without side rails. The 2018 facility assessment will be amended to include evaluation of beds per the FDA guidelines for entrapment. An inventory of beds in service will be conducted annually, to include pendant operation, side rail function, and proper operation of side rail lockout mechanisms. The facility assessment will also include resources to obtain equipment when the needs of the patient cannot be met by	

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F 838	Continued From page 23 #154, #155, #158 and #160) sampled residents and all other residents residing in the facility.	F 838	facility owned equipment. The amended facility assessment will be reviewed by the Quality Assurance Performance Improvement committee for approval. The facility assessments plan will be updated annually and as needed. QAPI Integration An internal full facility quality review will be conducted two times per year. The quality review will include a review of the facility assessment to ensure all regulatory requirements are included. Results will be reviewed at the Quality Assurance Performance Improvement committee. 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.	