



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE- Governor
DAVE JEPPESEN- Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
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P. O. Box 83720
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March 20, 2020

Sherrie Nunez, Administrator
Apex Center
8211 Ustick Road,
Boise, ID 83704-5756

Provider #: 135079

Dear Sherrie:

Congratulations to both you and your staff on your deficiency-free survey. In today's world with numerous regulations, it is indeed impressive to see a facility functioning as a team at this level.

Continuing to meet the needs of your residents – while recognizing and meeting the administrative needs of your business – is a daily commitment to quality ongoing assessment, care planning and consistent provision of services to each and every client. The greater challenge, of course, is to be able to work as a team to provide this high level of caring and service day after day, week after week, year after year.

Again, **Congratulations** to you and your staff for a job well done, and I challenge you to keep this same high standard in the coming year.

Sincerely,

DEBBY RANSOM, R.N., R.H.I.T.
Bureau Chief



DIRK KEMPTHORNE – Governor
KARL B. KURTZ – Director

IDAHO DEPARTMENT OF

HEALTH & WELFARE

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
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DR/dr

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

PRINTED: 03/23/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2020
NAME OF PROVIDER OR SUPPLIER APEX CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8211 USTICK ROAD BOISE, ID 83704		
(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	<p>INITIAL COMMENTS</p> <p>A recertification and complaint survey was conducted March 2, 2020 through March 5, 2020 at Apex Care Center. The facility was found to be in substantial compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Sallie Schwartzkopf, LCSW Debbie Abasciano, RN Kathi Davis, RN</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

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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April 17, 2020

Sherrie Nunez, Administrator
Apex Center
8211 Ustick Road
Boise, ID 83704-5756

Provider #: 135079

Dear Ms. Nunez:

On **March 2, 2020** through **March 5, 2020**, an unannounced on-site complaint survey was conducted at Apex Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008034

ALLEGATION #1:

The facility failed to ensure residents were provided timely care and treatment for urinary tract infections.

FINDINGS #1:

During the survey 17 residents were observed and records were reviewed for quality of care, dietary services, rehabilitation services, and resident assessments. The facility's Grievances and Resident Council Meeting minutes were reviewed and residents and staff were interviewed.

During observations 4 residents were observed receiving personal care and services appropriately with no concerns identified.

Sherrie Nunez, Administrator
April 17, 2020
Page 2 of 5

During the Resident Council Group Meeting, 13 residents stated they had no concerns with receiving treatment by the facility when they had a change of condition and required medications.

Three residents' records were reviewed for treatment received for UTI's. One resident's record documented the resident was admitted to the facility in May 2017 with a history of UTI's. The resident's record documented a urine sample was obtained and sent to the laboratory for culture and sensitivity. The physician was notified the results had not returned and the physician did not want to start antibiotics until the culture and sensitivity results of the urinalysis results came back. The resident was treated with antibiotics for a UTI 5 days later.

The Director of Nursing and the Infection Control Nurse stated the facility's laboratory was located in a different state at the time the resident had a delay in treatment for a UTI. The Director of Nursing and the Infection Control Nurse stated the facility changed laboratories based on this particular incident and now have a local laboratory and had no further concerns of receiving laboratory results timely.

Based on the investigative findings, the allegation was substantiated; however, no deficient practice was cited due to the facility's changing the laboratory to a local area.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #2:

The facility failed to provide palatable food to the residents.

FINDINGS #2:

The facility's Resident Council Meeting minutes were reviewed from December 2018 to March 2020 and no concerns were identified regarding food palatability. Thirteen residents attended the Resident Council Group Meeting and no concerns were identified regarding food palatability.

Seventeen residents were interviewed regarding food palatability and no concerns were identified. Three residents stated the facility had a new menu and cook and the food was great.

The facility's Grievances were reviewed from January 2019 to March 2020 regarding food palatability and no concerns were identified.

During dining observations four residents, two visitors, and one staff member were interviewed. The residents stated they had no concerns with the food palatability. Two visitors stated the food was very good and they had no concerns with the food palatability. One staff member was observed eating lunch with the residents who required restorative services during the meal. The staff member stated the food was palatability and had no concerns with the food services.

Based on the investigative findings, the allegation was unsubstantiated due to lack of evidence regarding the facility's food was not palatable for the residents.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility failed to ensure residents were provided with adequate bathing.

FINDINGS#3:

During the survey 24 residents were observed for grooming and odors. Residents records were reviewed for bathing. Resident Council Meeting minutes were reviewed, the facility's grievances were reviewed, and residents and staff were interviewed.

One shower aide was observed providing a shower to a resident. The shower aide stated the residents receive their showers per their individualized care plan. The shower aide stated the residents receive their showers and had no concerns with getting the showers completed.

Three resident's records were reviewed for showers and their records documented they received two showers a week per their individualized care plan. One resident's record documented they were to receive three showers a week. One resident stated he was scheduled for three showers per week, but will decline at times when his preferred CNA was not working. The resident stated he had no concerns with 2-3 showers per week.

Thirteen residents attended the Resident Group Meeting and had no concerns regarding showers. They stated they receive their showers based on their care plan.

The Resident Council Meeting minutes were reviewed from January 2019 to March 2020 and no concerns were identified regarding residents not receiving showers. The facility's grievances were reviewed from January 2019 to March 2020 and no concerns were identified regarding residents not receiving showers.

Sherrie Nunez, Administrator
April 17, 2020
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Based on the investigative findings, the allegation was unsubstantiated due to lack of evidence regarding the facility not providing adequate showers to the residents.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility failed to ensure restorative services were provided to the residents.

FINDINGS #4:

Three resident's records were reviewed for restorative services. One resident's record documented he received restorative services. The resident stated he declines restorative services one time a week because he goes out of the facility for physical therapy. The resident stated he received restorative services and had no concerns with the program.

The Restorative Nursing Manager stated the restorative aides were scheduled to work as restorative aides. She stated when the restorative aides were pulled to work the floor as a CNA, she assured the residents received their restorative therapy services.

Based on the investigative findings, the allegation was unsubstantiated due to lack of evidence regarding the facility not providing restorative services to the residents.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The facility failed to ensure residents were seen by a physician routinely.

FINDINGS #5:

Seventeen residents' records were reviewed for physician visits and no concerns were identified. One resident's record documented the resident was seen by the physician more than the regulatory requirement. The resident stated he was seen by the physician or the nurse practitioner routinely and had no concerns with visiting with the physician when he had concerns regarding his care.

The Nurse Practitioner stated she came to the facility once a week and the physician came once a week to the facility to see residents. She stated the facility provided a list of residents that were required to be seen as well as residents on an as needed basis.

Sherrie Nunez, Administrator
April 17, 2020
Page 5 of 5

Based on the investigative findings, the allegation was unsubstantiated due to lack of evidence regarding the facility not meeting the regulatory requirement for residents to be seen by a physician.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

One of the allegations was substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in cursive script that reads "Belinda Day".

Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj



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DAVE JEPPESEN – Director

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April 17, 2020

Sherrie Nunez, Administrator
Apex Center
8211 Ustick Road,
Boise, ID 83704-5756

Provider #: 135079

Dear Ms. Nunez:

On **March 2, 2020** through **March 5, 2020**, an unannounced on-site complaint survey was conducted at Apex Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008039

Allegation #1: The facility failed to ensure physical therapy services were provided as ordered.

Findings #1: During the survey, observations and interviews were conducted, the facility's Grievances, Resident Council Meeting minutes, and resident records were reviewed.

The facility's Grievances were reviewed from December 2018 to March 2020 regarding residents not receiving therapy services per physician's orders and no concerns were identified.

The Resident Council Meeting minutes were reviewed from January 2019 to March 2020 regarding residents not receiving therapy services and no concerns were identified. During the Resident Group Meeting, 13 residents stated they had no concerns with receiving therapy.

Three residents were observed at the therapy gym receiving therapy, two residents were observed in their room receiving therapy, and one resident was observed ambulating the hallway with a therapist. During the observations, there were no concerns identified with residents receiving therapy.

Four resident's records were reviewed for therapy services. One resident's record documented the resident was admitted to the facility in January 2019 to receive Physical Therapy, Occupational Therapy, and Speech Therapy. The resident's record documented the resident was seen by Physical and Occupational therapy five times a week during the resident's stay with no concerns identified.

Based on the investigative findings, the allegation was unsubstantiated due to lack of evidence regarding residents not receiving therapy services per physician's orders.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The facility was not notifying family representatives of residents when they acquired pressure ulcers.

Findings #2: During the survey, one resident was observed receiving wound care management by the Wound Nurse. The Wound Nurse stated the resident was admitted to the facility with a pressure ulcer and it was healing well with current wound care management. The Wound Nurse was observed providing appropriate infection control precautions and no concerns were identified.

Three resident's records were reviewed for wound care management. During the review of records for one resident, admitted January 2019 documented the resident did not have pressure ulcers and was not a high risk for developing pressure ulcers. The resident's record documented weekly skin assessments were performed by licensed staff and no concerns were identified. Upon discharge the resident's record documented the resident did not have any type of skin impairments and no concerns for pressure ulcers. The Wound Nurse stated the resident did not have pressure ulcers or skin impairments during the stay at the facility. The Wound Nurse stated the resident did not have physician's orders for wound care management.

Based on the investigative findings, the allegation was unsubstantiated due to lack of evidence regarding residents acquiring pressure ulcers and the family representative was not notified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The facility was not providing supervision during meal times to ensure residents received adequate hydration.

Findings #3: During dining observations, residents were observed with the facility staff offering fluids and the staff assisting residents with fluids if needed. Two residents were observed receiving restorative services during the meals. The restorative aide assisted the resident with fluids between each bite of food. During the dining observation, there were four staff members passing trays to the residents. Three CNAs were observed assisting residents with their meals including fluids. Four staff members were observed in the dining room until every resident was finished with their meal. A CNA stated she was assigned to be in the dining room until everyone was finished.

Six residents were observed with fluids at the bedside to drink throughout the day. Five residents stated the CNAs refilled their water mugs with ice and water every shift. One resident stated the facility provided her with bottled water and which was observed at her bedside.

One CNA was observed dumping water out of the residents' mugs and refilling them with fresh ice and water on one of the 3 halls. The CNA stated one of the daily assignments was to provide fresh ice water to all residents, who may have water at their bedside, every shift. The CNA stated residents who required thickened liquids received assistance throughout the day.

Six residents records were reviewed for hydration. One resident's record documented the resident was admitted with a UTI and had a catheter. The resident's record documented the resident's urine in the bag was clear and yellow. The resident's record documented the resident received thickened liquids and the facility was assisting the resident with meals. The resident's record documented the resident was receiving adequate fluid intake.

Based on the investigative findings, the allegation was unsubstantiated due to lack of evidence regarding residents not receiving adequate hydration.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: The facility failed to ensure residents consented to room transfers.

Findings #4: The facility's Grievances were reviewed from January 2019 to March 2020 regarding residents room changes without consent by the family or the resident. No concerns were identified.

During the Resident Group Meeting, 3 residents stated they requested to have a room change and the facility accommodated their requests. One resident stated the LSW offered for her to move into a room to be with her spouse. The resident stated the LSW did not make her change rooms, it was her choice.

The LSW stated residents were admitted to the short term hall and the resident stayed long term, it was their choice to move to the long term care hall. The LSW stated if the resident declined to move to a different hall, it was their right to stay in the same room.

Sherrie Nunez, Administrator
April 17, 2020
Page 4 of 4

One resident's record documented a room change from one hall to another hall. The DNS stated all the residents' on that hall were all moved to a different hall due to a water leak.

Based on the investigative findings, the allegation was unsubstantiated due to lack of evidence residents were moved from their room without consent.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: The facility staff were not using gait belts to transfer residents.

Findings #5: During the survey, CNAs were observed transferring residents using a gait belt and no concerns were identified. A CNA stated when transferring residents that were able to stand, they used the gait belt for safety. Two CNAs were observed transferring a resident using a sit to stand with no concerns identified. Two CNAs were observed transferring a resident using a hoist mechanical lift and no concerns were identified.

The DNS stated all nursing staff were required to use proper safety equipment during transfers. The DNS stated each nursing staff member was observed transferring residents with all safety devices upon hiring and annually. The DNS stated did spot checks to ensure the staff were using proper mechanics for safety.

Based on the investigative findings, the allegation was unsubstantiated due to lack of evidence staff were not using gait belts on residents during transfers.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



BELINDA DAY, RN, Supervisor
Long Term Care Program

BD/ac



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April 17, 2020

Sherrie Nunez, Administrator
Apex Center
8211 Ustick Road,
Boise, ID 83704-5756

Provider #: 135079

Dear Ms. Nunez:

On **March 2, 2020** through **March 5, 2020**, an unannounced on-site complaint survey was conducted at Apex Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008095

Allegation: The facility is not providing housekeeping services in residents rooms.

Findings: During the survey 17 resident rooms were observed for cleanliness and organization. Resident Council minutes were reviewed, facility grievances were reviewed, and resident and staff were interviewed.

During observation of resident rooms, 17 rooms were clean and organized. Six residents stated the rooms were cleaned daily by the housekeepers. One resident's room was clean and organized. The resident stated a housekeeper cleaned her room, wiped off the furniture and mopped every day.

Sherrie Nunez, Administrator
April 17, 2020
Page 2 of 2

Resident Council Meeting minutes and the facility's grievances were reviewed from December 2018 to March 2020. The Resident Council minutes documented in September 2019 there was a concern the housekeepers were not mopping under residents' beds. The minutes in October 2019 documented the concern was addressed and was no longer a concern. The facility's grievances were also reviewed and no concerns were identified regarding cleanliness of resident rooms.

A housekeeper stated two housekeepers were assigned to clean each room seven days a week. She stated she was assigned to two halls and the other housekeeper was assigned to the other two halls. The housekeeper stated she was responsible to wipe down all the surfaces in each resident room and sweep and mop the floors, including each resident's bathroom.

The Housekeeper Supervisor stated two housekeepers were assigned to 2 of the 4 halls to clean each room seven days a week. He stated each housekeeper has a documented checklist for each room on each hall to be handed in daily to assure each room was cleaned. He stated if a resident declined to have their room cleaned, the housekeeper documented the resident declined services on the specific date. He stated he reviewed the completed checklist daily and if he identified a pattern a resident was declining housekeeping services, he talked to the housekeeper about why the resident declined and then would work with the resident to find out their preference for cleaning their room.

Based on the investigative findings, the allegation was unsubstantiated due to lack of evidence regarding the facility not providing daily housekeeping services.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



BELINDA DAY, RN, Supervisor
Long Term Care Program

BD/ac



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April 17, 2020

Sherrie Nunez, Administrator
Apex Center
8211 Ustick Road,
Boise, ID 83704-5756

Provider #: 135079

Dear Ms. Nunez:

On **March 2, 2020** through **March 5, 2020**, an unannounced on-site complaint survey was conducted at Apex Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008297

Allegation #1: Residents' call lights were not accessible or answered timely.

Findings #1: During the survey 17 residents were observed and records were reviewed for Quality of Care, falls, and transferring residents appropriately. Resident Council meeting minutes were reviewed, facility grievances were reviewed, and residents and staff were interviewed.

During observations 17 residents were observed with their call lights within reach and their call lights were answered within 5 minutes or less and timely assistance was provided. Seventeen residents' records were reviewed for call light accessibility and timely response and no concerns were identified. Seventeen residents stated the staff answered their call lights timely and were accessible.

Resident Council Meeting minutes and the facility's grievances from December 2018 to March 2020 were reviewed and no concerns were identified regarding call light accessibility and call lights being answered timely.

During the resident group interview, 13 residents stated the staff were very timely answering call lights and providing assistance when needed. The residents stated the staff ensured the call light was accessible for the residents.

Three CNAs stated they ensured residents had their call light within reach and answered the call lights promptly. Two licensed nurses stated they assisted the CNAs with answering call lights to ensure the residents received the care and services they deserved in a timely manner. The DNS stated all staff are expected to answer the residents' call lights and if the staff member was unable to provide nursing services for the resident they were to keep the call light on and go find nursing assistance for the residents. The Administrator stated when residents' went on their smoke breaks, a manager accompanied them to supervise, so the nursing staff remained on the floor to assist residents with personal cares.

Based on the investigative findings, the allegation was unsubstantiated due to lack of evidence call lights were not accessible and answered timely for the residents.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Residents were assisted to sit up in bed and were left alone to fall.

Findings #2: During the survey two residents were observed and three resident's records, which included one closed record, were reviewed for incident and accidents. Residents and staff were interviewed.

Three residents' records were reviewed for falls. One resident was admitted in October 2019, with a femur fracture related to a fall at home. An incident and accident report documented the resident requested to have assistance to sit up on the side of the bed. The report documented the bed was lowered to have the resident have her feet touch the floor on the side of the bed. The report documented 10 minutes later the resident was found on the opposite side of the bed on the floor and sustained no injuries. The facility's investigation documented the resident was administered Tramadol 5 hours prior to her fall. The report documented the resident had a new onset of confusion, when usually she was alert and orientated. The report documented the physician reviewed the fall investigation and medications and determined the resident had previously fallen at home while taking Tramadol. The physician discontinued the Tramadol and continued the Norco for pain management. The resident's record documented the resident was clear minded the next day and throughout her stay at the facility.

Sherrie Nunez, Administrator
April 17, 2020
Page 3 of 4

The DNS stated the resident was alert and orientated when she was admitted to the facility. The resident was receiving Norco for pain management until the family requested the resident to use Tramadol for pain like she did before admission. The DNS stated 5 hours later the resident fell and was slightly confused when previously she was very alert and clear minded. The DNS stated the resident received one dose of the Tramadol and then it was discontinued due to the resident's fall and confusion.

Based on the investigative findings, the allegation was substantiated, however no deficient practice was cited for leaving a resident sitting up on the side of the bed alone.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

Allegation #3: The facility's staff transferred residents to bed causing pain to their injured extremity.

Findings #3: During observations staff were observed transferring 7 residents into bed or wheelchair with no concerns identified. Seven residents stated they have no concerns with staff assisting them with transferring. Two resident records were reviewed for injured extremities that required assistance. One resident had bilateral fractured wrists and wore a brace and splint. The resident stated her pain is currently management with her current pain regimen and staff assisted her carefully and did not cause pain during cares.

Resident Council Meeting minutes and the facility's grievances from December 2018 to March 2020 were reviewed and no concerns were identified regarding staff mistreating residents causing pain during transfers.

During the resident group interview, 13 residents stated the staff transferred the residents' safely and did not cause pain during the transfer.

One resident's record documented she had a non-surgical femur fracture and wore a knee brace for protection. The resident's record documented she required extensive assistance of one staff member for transfers and bed mobility. The resident's record documented her pain was managed and assessed effectively.

Based on the investigative findings, the allegation was unsubstantiated due to lack of evidence the staff caused pain to residents during transfers.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

One of the allegations was substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sherrie Nunez, Administrator
April 17, 2020
Page 4 of 4

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in cursive script that reads "Belinda Day". The signature is written in black ink and is positioned above the typed name and title.

BELINDA DAY, RN, Supervisor
Long Term Care Program

BD/ac