

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

PRINTED: 08/26/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135114</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/16/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST LUKE'S REHAB - ELKS SUB ACUTE REHAB UNIT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 NORTH ROBBINS ROAD BOISE, ID 83702</b>		
(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	
E 000	<p>Initial Comments</p> <p>A COVID-19 Focused Emergency Preparedness Survey was conducted by the Centers for Medicare &amp; Medicaid Services (CMS) Seattle on 6/16/20. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6).</p> <p>Total residents: 10</p>	E 000			

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

TITLE

(X6) DATE

Electronically Signed

07/01/2020

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.

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

PRINTED: 08/26/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135114</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/16/2020</b>
--	---	--	---

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

(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><b>INITIAL COMMENTS</b></p> <p>A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicare &amp; Medicaid Services (CMS) Seattle on 6/16/20.</p> <p>A deficiency was cited.</p> <p>The survey sample, based on a resident census of 10 included 3 sampled residents and 2 unsampled residents.</p> <p>The CMS Seattle team member was: Terry Aoki, RN</p> <p>CMS Seattle federal surveyors can be reached at: US Department of Health and Human Services Centers for Medicare and Medicaid Services 701 Fifth Avenue Suite 1600 Region 10, mailstop 400 Seattle, WA 98104 206.615.2313 206.615.2088 (Fax)</p>	F 000		
F 880 SS=E	<p>Infection Prevention &amp; Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program.</p>	F 880		7/15/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/01/2020

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.

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

PRINTED: 08/26/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135114</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/16/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST LUKE'S REHAB - ELKS SUB ACUTE REHAB UNIT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 NORTH ROBBINS ROAD BOISE, ID 83702</b>		
(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 880	<p>Continued From page 1</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p>	F 880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135114</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/16/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST LUKE'S REHAB - ELKS SUB ACUTE REHAB UNIT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 NORTH ROBBINS ROAD BOISE, ID 83702</b>		
(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 880	<p>Continued From page 2</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment to prevent the transmission of communicable diseases and infections when the facility failed to practice universal precautions when staff failed to utilize a barrier for a multi-resident use glucometer after use on 2 of 2 unsampled residents (R) (R4 and R5) and 1 sampled resident (R3) for 3 of 3 blood sugar monitoring observation. These failures increased the risk for the spread of infection and its associated complications.</p> <p>Findings include: During Entrance interview on 6/16/20 at 12:00 PM Administrator and Director of Nursing (DON) stated that facility census was 10 and the facility had no current COVID-19 positive residents or staff.</p>	F 880	<p>Responsible Party: Jo Phillips, RN, Director of Nursing</p> <p>Immediate Corrective Action: Surfaces in the room and at the nurses station where the glucometers were placed were cleaned to remediate contamination.</p> <p>Identification of Other Residents: Patients who receive Point of Care blood sugar testing have the potential to be affected.</p> <p>Corrective Measures To Be Taken: 1. Implement a process to include utilizing a barrier that the glucometer is placed on to prevent contamination of the resident's environment. Kathy Pierce, RN, Infection Preventionist, responsible for the measure. Completion Date 6/18/20.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135114</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/16/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST LUKE'S REHAB - ELKS SUB ACUTE REHAB UNIT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 NORTH ROBBINS ROAD BOISE, ID 83702</b>		
(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 880	Continued From page 3 Observation on 6/16/20 at 5:05 PM showed Certified Nursing Assistant (CNA)1 and CNA2 at the nursing station. The glucometer was wrapped in grey top sani cloth wipe. CNAs walked to R5's room carrying glucometer, lancet, gauze, alcohol swab, and strips. Both CNAs were gloved, CNA2 scanned R5's identification wrist band with glucometer and then placed glucometer on resident's overbed table. No protective barrier was placed under glucometer. CNA2 placed strip into glucometer, swab resident's finger with alcohol and then pricked finger with lancet with a small bead of blood shown. CNA2 brought glucometer towards blood and blood was shown on the strip inserted in glucometer. Blood sugar reading was obtained. CNA2 placed lancet in sharps container and removed gloves and performed hand hygiene. CNA2 then tucked glucometer under her arm and walked to nursing station. CNA2 placed glucometer on nursing station counter. No barrier was used to protect nursing station counter from used glucometer. CNA2 removed sani cloth wipes from container and wiped and wrapped glucometer with sani cloth wipes. Nursing CNA1 observed CNA2 performing blood sugar check for R5. CNA1 stated that she was going to R3's room to bring R3 a warm blanket in preparation for blood sugar testing. CNA2 then entered R4's room and proceeded with the above tasks. Again placing glucometer on resident's overbed table without protective barrier before checking blood sugar and on resident's hand sink after checking blood sugar. CNA2 again tucked used glucometer under her arm when exiting the room and placed glucometer on nursing station counter. No barrier was used to protect resident's hand sink or nursing station counter from used glucometer. CNA2 cleaned glucometer with sani cloth wipes	F 880	2. Educate staff performing point of care glucose testing on the use of the barrier. Brett Gustafson, RN, Nursing Supervisor, responsible for the measure. Completion Date 7/15/20.  Compliance Monitoring: 1. Observation audits of blood glucose testing process to verify new process is followed. Audits will specifically collect data of compliance with using a barrier. Audits will be conducted weekly for 4 weeks, then every other week for two months, and monthly for 3 months.  2. Completion of education for staff performing point of care glucose testing will be verified by attendance rosters.  QAPI Reporting and Review: Results of the audits and education rosters will be reviewed at the time of completion with unit leadership and reviewed monthly during the Quality Collaborative.		

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

PRINTED: 08/26/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135114</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/16/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST LUKE'S REHAB - ELKS SUB ACUTE REHAB UNIT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 NORTH ROBBINS ROAD BOISE, ID 83702</b>		
(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 880	<p>Continued From page 4</p> <p>and walked to R3's room placing glucometer on resident's overbed table before checking blood sugar and again after checking blood sugar. CNA2 then tucked glucometer under her arm and walked to nursing station. CNA2 placed glucometer on nursing station counter. No barrier was used to protect nursing station counter from used glucometer. CNA2 removed sani cloth wipes from container and wiped and wrapped glucometer with sani cloth wipes.</p> <p>During an interview on 6/16/20 at 5:55 PM with Nursing Unit Supervisor (NUS), DON, and IP. IP stated that barrier should be used after glucometer is used to protect resident's environment and other surfaces before the glucometer can be cleaned. NUS stated that protective barriers with glucometers have never been used before and interviews with CNAs would confirm that.</p> <p>During Exit interview on 6/16/20 at 6:00 PM with DON, IP, NUS, and Administrator, no additional information was provided.</p> <p>Record review of progress notes and physician orders showed R3 was admitted to the facility on 6/9/20 with diagnosis including post coronary artery bypass graft procedure and diabetes (A disease that makes the person more susceptible to developing infections, as high blood sugar levels can weaken the person's immune system defenses. In addition, some diabetes-related health issues, such as nerve damage and reduced blood flow to the extremities, increase the body's vulnerability to infection.).</p> <p>Facility technical procedure, "POCT (Point of Care Testing) Glucose Testing by Nova StatStrip",</p>	F 880			

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

PRINTED: 08/26/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135114</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/16/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST LUKE'S REHAB - ELKS SUB ACUTE REHAB UNIT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 NORTH ROBBINS ROAD BOISE, ID 83702</b>		
(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 880	Continued From page 5 revised date 5/8/20, showed staff should clean and disinfect the meter after each patient test. The procedure did not detail when the meter should be cleaned and disinfected (such as immediately after use), where the meter should be cleaned (such as either in the resident's room or taken out of the resident's room), or how staff should protect the meter to ensure it did not contaminate the resident's environment after use especially if the meter was not cleaned/disinfected immediately and taken out of the resident's room.  Centers for Disease Control and Prevention Guidelines for Environmental Infection Control in Health-Care Facilities (2003), <a href="https://www.cdc.gov/infectioncontrol/guidelines/environmental/index.html">https://www.cdc.gov/infectioncontrol/guidelines/environmental/index.html</a> , accessed 6/17/20 showed under "Recommendations - Environmental Services" on subsection "Cleaning and Disinfecting Strategies for Environmental Surfaces in Patient Care Areas," "...3. Use barrier protective coverings as appropriate for noncritical surfaces that are 1) touched frequently with gloved hands during the delivery of patient care; 2) likely to become contaminated with blood or body substances..."	F 880			