



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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E-mail: fsb@dhw.idaho.gov

August 2, 2019

Nolan Hoffer, Administrator
St Luke's Rehab - Elks Sub Acute Rehab Unit
PO Box 1100
Boise, ID 83702-4565

Provider #: 135114

Dear Mr. Hoffer:

On **July 26, 2019**, a survey was conducted at St Luke's Rehab - Elks Sub Acute Rehab Unit by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 12, 2019**. Failure to submit an acceptable PoC by **August 12, 2019**, may result in the imposition of penalties by **September 4, 2019**.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **August 30, 2019 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **October 24, 2019**. A change in the seriousness of the deficiencies on **September 9, 2019**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **October 26, 2019** includes the following:

Denial of payment for new admissions effective **October 26, 2019**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 26, 2020**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **October 26, 2019** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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Go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

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

This request must be received by **August 12, 2019**. If your request for informal dispute resolution is received after **August 12, 2019**, 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 Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

bd/lj

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

PRINTED: 08/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/26/2019
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NAME OF PROVIDER OR SUPPLIER ST LUKE'S REHAB - ELKS SUB ACUTE REHAB UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 600 NORTH ROBBINS ROAD BOISE, ID 83702
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(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
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F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility from July 23, 2019 to July 26, 2019. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Juanita Steman, RN Survey Abbreviations: HIM = Health Information Management RN = Registered Nurse	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the	F 623		8/26/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 08/09/2019
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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 623	<p>Continued From page 1</p> <p>resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and</p>	F 623			

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F 623	<p>Continued From page 2</p> <p>telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure transfer notices were provided in writing to residents and residents' representatives. This was true for 1 of 2 residents (Resident #6)</p>	F 623	<p>Responsible party: The Director of Nursing is ultimately responsible for ensuring that transfer notices are provided to residents and/or resident <input type="checkbox"/>s representatives.</p>		

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F 623	<p>Continued From page 3</p> <p>reviewed for transfers. This created the potential for harm if residents were not made aware of or able to exercise their rights related to transfers. Findings include:</p> <p>The facility's transfer and discharge policy, dated 1/31/19, documented when transferred emergently, residents or their legal representatives were to receive a written reason for transfer as soon as practical.</p> <p>This policy was not followed.</p> <p>Resident #6 was admitted to the facility on 6/14/19, with multiple diagnoses including muscle weakness.</p> <p>Resident #6's Nurses' Progress Notes documented he was transferred to the hospital for evaluation on 6/21/19, when he became unresponsive. Resident #6's record did not include a written notice of transfer to him or his representative.</p> <p>On 7/26/19 at 8:47 AM, the RN Supervisor said the HIM Department was responsible to provide residents and their representatives with the transfer notices.</p> <p>On 7/26/19 at 8:55 AM, the HIM Manager said the facility had not provided written transfer notices to residents or their representatives when they were transferred emergently to the hospital.</p>	F 623	<p>Immediate Response: The resident identified during survey was discharged from the facility prior to identification.</p> <p>Identification of other residents: The facility has determined that all residents who are to be transferred have the potential to be affected by this deficient practice.</p> <p>Measures taken: Notification of transfer process was reviewed and updated to ensure compliance with regulatory standards. Staff including, Nursing, administrative support, and discharge planners were provided education on the expectations on notification of a resident transfer. Staff education was completed via a variety of ways including, in-service, policy review, as well as one to one interaction.</p> <p>Compliance Monitoring: The Director of Nursing, or designee, will conduct an audit of residents who have been transferred to ensure proper notification occurred. Audits will be conducted weekly for 1 month and progress to monthly for the following 3 months. Results of the audit will be reviewed with facility leadership, with appropriate follow up conducted as necessary for areas of non-compliance. Results will be reviewed at the Quality Assurance and Performance Improvement Committee monthly as well.</p>		
F 625	Notice of Bed Hold Policy Before/Upon Trnsfr	F 625		8/26/19	

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F 625 SS=D	Continued From page 4 CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a notice of bed hold policy was provided to the residents or their representatives upon transfer to the hospital. This was true for 1 of 2 residents (Resident #6) reviewed for transfers.	F 625	Responsible party: The Director of Nursing is ultimately responsible to ensure that residents or their representatives will be provided a notice of the bed hold policy upon transfer to the hospital.		

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F 625	<p>Continued From page 5</p> <p>This deficient practice created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time and may cause psychosocial distress if not informed they may be charged to reserve their bed/room. Findings include:</p> <p>The facility's Bed Hold policy, dated 12/31/18, documented the residents or their legal representatives were to receive a written bed hold notice within 24 hours of an emergent transfer.</p> <p>This policy was not followed.</p> <p>Resident #6 was admitted to the facility on 6/14/19, with multiple diagnoses including muscle weakness.</p> <p>Resident #6's Nurses' Progress Notes documented he was transferred to the hospital for evaluation on 6/21/19, when he became unresponsive. Resident #6's record did not include documentation a written notice of bed hold policy was provided to him or his representative.</p> <p>On 7/26/19 at 8:55 AM, the HIM Manager said the facility did not provide a bed hold notice to Resident #6 or his representative because the facility would readmit Resident #6 upon discharge from the hospital. She said the bed hold policy was given to residents or their representatives when they were admitted to the facility and were not given the notice when they were transferred emergently to the hospital.</p>	F 625	<p>Immediate Response: The resident identified during survey was discharged from the facility prior to identification.</p> <p>Identification of other residents: The facility has determined that all residents who are to be transferred have the potential to be affected by this deficient practice.</p> <p>Measures taken: Notification of bed hold policy was reviewed and updated to ensure compliance with regulatory standards. Staff including, Nursing, administrative support, and discharge planners were provided education on the expectations on notifying residents of the bed hold policy. Staff education was completed via a variety of ways including, in-service, policy review, as well as one to one interaction.</p> <p>Compliance Monitoring: The Director of Nursing, or designee, will conduct an audit of residents who have been transferred to ensure proper notification of the bed hold policy occurred. Audits will be conducted weekly for 1 month and progress to monthly for the following 3 months. Results of the audit will be reviewed with facility leadership, with appropriate follow up conducted as necessary for areas of non-compliance. Results will be reviewed at the Quality Assurance and Performance Improvement Committee monthly as well.</p>		

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F 812 SS=F	<p>Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements. The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, it was determined the facility failed to ensure kitchen equipment and shelves were maintained in a sanitary manner, placing 7 of 7 residents (#2, #3, #4, #55, #56, #105, & #106) residing in the facility, at risk for foodborne illness. Findings include:</p> <p>The facility's procedure titled, Ecolab: Procedures: Ice Machine/Ice Cart - Cleaning & Sanitizing, dated 1/14/11, documented the ice machine should be cleaned twice monthly and included the removal of the ice and scrubbing of built-up deposits with a nylon brush or scraper.</p>	F 812	<p>Responsible party: The Food and Nutrition Services Manager is ultimately responsible to ensure kitchen equipment and shelves are maintained in a sanitary manner.</p> <p>Immediate Response: At the time of survey the following steps were taken to ensure compliance; the debris was immediately cleaned from the shelf and the shelf was sanitized; the debris was immediately cleaned from table mixer and the mixer was sanitized; the debris was immediately cleaned from the flour and</p>	8/26/19	

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F 812	<p>Continued From page 7</p> <p>The facility procedure titled, Equipment & Safety Standards for Food and Nutrition, undated, documented staff were to remove from use any dirty or soiled equipment.</p> <p>On 7/25/19 at 9:48 AM, the following observations were made in the kitchen with the facility Food Services Supervisor (FSS):</p> <p>Inside the ice machine there was a brown buildup along the upper and lower ledge of the ice exit shoot, located directly above the stored ice. On the left side of the ice machine there were several pots and pans stored on shelves. On the surface of one of the shelves, there was black debris observed next to clean cooking sheets. The cooking sheets were standing on their edges next to the debris. The facility's Weekly Cleaning List documented the ice machine was scheduled for cleaning every Friday and the bottom shelves were scheduled for cleaning every Sunday.</p> <p>In the food preparation area there was a small table mixer stored on a metal table. The mixer had dried yellow and white food debris on the base of the mixer. At that time, the FSS confirmed the mixer had not been recently used for a meal. Debris and dust were observed on the lids of the large sugar and flour bins.</p> <p>During the tour of the kitchen, three soiled oven mitts were observed resting on top of one of the steam kettles. Cook #1 confirmed the mitts were not being used during meal preparation on 7/25/19. The FSS stated soiled mitts were to be replaced with clean ones.</p>	F 812	<p>sugar bins and the bins were sanitized; the soiled oven mitts were removed from operation and replaced and the ice machine was immediately turned off and emptied and cleaned.</p> <p>Identification of other residents: Due to the nature of the deficient practice all residents are at risk of being affected.</p> <p>Measures taken: The identified areas of concern were addressed to ensure compliance.</p> <p>The ice machine utilization was reviewed and determined to be unnecessary. Based on this determination the ice machine has been removed from use.</p> <p>The kitchen staff were re-educated on the expectations for kitchen sanitation as outlined in the facility's procedure manual titled: Equipment and Safety Standards for Food and Nutrition. Education was completed via a variety of ways including, in-service, policy review, as well as one to one interaction.</p> <p>Compliance Monitoring: In order to ensure ongoing compliance, food and nutrition site leadership will conduct random weekly audits until 9/1/19, then transition to monthly audits for three months. Audit results will be reviewed monthly at the Food and Nutrition Staff meeting and shared with the Quality Assurance and Performance</p>		

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

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NAME OF PROVIDER OR SUPPLIER ST LUKE'S REHAB - ELKS SUB ACUTE REHAB UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 600 NORTH ROBBINS ROAD BOISE, ID 83702		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 812	Continued From page 8 The FSS did not provide documentation as to when the kitchen equipment was last cleaned. On 7/25/19 at 2:05 PM, the FSS stated he expected the cleaning tasks to be done to maintain cleanliness of the kitchen and the equipment.	F 812	Improvement committee.		