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HEALTH & WELFARE

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November 9, 2018

Jamie Newton, Administrator
Southwest Idaho Treatment Center
1660 Eleventh Avenue North
Nampa, ID 83687

Provider #13G001

Dear Ms. Newton:

An unannounced on-site complaint investigation was conducted from October 22, 2018 to October 25, 2018 at Southwest Idaho Treatment Center. The complaint allegation, findings, and conclusion are as follows:

Complaint #ID00007878

Allegation: The facility continues to employ staff who have an employment history of individual abuse, neglect or mistreatment.

Findings: An unannounced on-site full survey and complaint investigation was conducted from 10/22/18 to 10/25/18. During that time, records were reviewed, and interviews were conducted with the following results:

The facility's system for the prevention and detection of abuse, neglect and mistreatment were reviewed. The facility forwarded all completed abuse, neglect and mistreatment investigations, involving adult residents, to the State of Idaho, "Adult Protection, Area 3 Senior Services Agency." In each case presented below, the Adult Protection Services (APS) Worker assigned to review the investigative report completed by the facility, conducted a desk audit and applied a "51% Rule" to determine if an allegation was "substantiated." The 51% Rule was defined by Adult Protection Services employees as "more likely than not" to have occurred. In the cases presented below, there was no documented evidence the Adult Protection Worker conducted an independent investigation including observations, interviews or record reviews prior to determining the allegation was substantiated.

Once the Adult Protection Worker substantiated an allegation, it was forwarded to other entities in the State of Idaho, and to the Nampa Police Department for possible investigation of criminal charges. The facility was not on the distribution list and was not notified the Adult Protection Worker had substantiated allegations which had been unsubstantiated by the facility. There was no evidence the police elected to investigate any of the allegations listed below for possible criminal activity, although in one case the police did conduct preliminary inquiries prior to closing the case.

The facility's investigations were also reviewed during the survey process to ensure compliance with applicable Federal regulatory requirements. The Code of Federal Regulations (CFR) state that if the alleged violation is verified, appropriate corrective action must be taken (42 CFR 483.420(d)(4)). The regulations do not require that employees be terminated, but that the facility imposes corrective action which is in proportion to the violation.

Multiple facility investigations and corrective actions taken in response to substantiated allegations were reviewed. There was insufficient evidence to establish the facility failed to comply with regulations. Examples included, but were not limited to, the following:

a. Investigation A-17-015 documented on 4/22/17 an individual known to have a seizure disorder was taken to a community-based dance with other individuals and multiple staff. During the outing the individual experienced a seizure. The investigative question used by the facility was whether the individual received care and treatment in response to her seizure in accordance with policy and as directed by her individual plan. The determination of the investigation was initially unsubstantiated as an allegation of neglect, however, upon administrative review, the determination was changed to substantiated. In a document dated, 05/11/17, the Administrator documented, "I am actually going to disagree with the investigators findings on this report and say that neglect did occur, though exactly who is responsible overall is tough to determine. I am going to say that in general, the treatment teams (not just {name of individual who had the seizure's} team) is responsible as there were several things along the way where clear direction was not given. Because of this there are several things that I want completed to avoid this type of situation in the future." The document identified actions to be implemented including revising policy related to calling 911 in an emergency, revising the community activity form to include information as to which staff were in charge, administrative changes to assure coverage for community outings met required ratios and to assure staffing ratio requirements were correct.

All employees involved in the allegation, as well as all facility staff, received training on the changes in policy and procedure regarding off campus events and calling 911. The facility determination was that no one employee was responsible for neglect and saw the issue as a lack of training and clarity in policy and procedures.

The APS worker's review of the information included in the investigative file resulted in the application of the 51% rule and the APS worker substantiated the allegation as neglect. Based on substantiation by the APS worker, this case was sent to the Nampa Police Department for consideration of criminal charges. There was no documented evidence the police ever came to the facility to investigate the allegation for possible criminal charges.

The facility's decision to not terminate all employees involved in the allegation did not violate federal regulation.

b. Investigation A-17-019 (initially unsubstantiated by the facility as neglect but, upon Administrative Review and reinvestigation, substantiated as medical neglect by the facility, based on "a systems failure" rather than as neglect against Employee E, an Licensed Practical Nurse (LPN)): an allegation of failure to provide needed medical care was reported on 05/15/17 and the investigation was initiated on that date. Employee E was removed from duty on 05/15/17 and returned to duty on 05/18/17 when the allegation was unsubstantiated.

The investigative findings stated an individual was seen in urgent care on 04/29/17 when he fell and reinjured his elbow. Significant data were present which documented the individual's unwillingness or inability to keep bandages on and to comply with leaving the wound alone to heal and wearing a long-sleeve shirt with elbow pads to protect the wound.

The Administrator was interviewed beginning at 10:07 AM on 10/24/18. The Administrator reported that in July 2017, a Nampa Police Detective came to the campus and presented a subpoena for the records related to this incident. Reportedly, the police detective interviewed staff and the facility investigator. According to the Administrator, the facility had already "re-opened" the case, originally unsubstantiated as an allegation of neglect against Employee E. According to the Administrator, during the conduct of the second investigation, the facility determined there was a flaw in the system related to the implementation of medical orders. Prior to the police coming to the facility to subpoena records and interview staff, the facility revised policy and procedures to lessen the likelihood that medical orders would go unresolved. According to the Administrator, once the police investigator reviewed records and interviewed staff, the police investigator indicated she was closing the case and no further action would be taken. The Administrator reported all medical staff were re-trained about the revised process to assure medical orders were fully resolved and Employee E was re-trained related to documentation requirements.

Although the allegation was substantiated, it was the facility's determination that rather than neglect being substantiated against the LPN, the facility substantiated medical neglect due to the facility's failure to develop and implement a system which assured medical orders were resolved. The investigative documents were found to be thorough and the Nampa Police Detective determined there were no grounds to proceed with criminal charges against the LPN.

c. Investigation A-17-006 (substantiated by the facility as neglect): the facility substantiated Employee A was asleep for more than an hour beginning at 1:57 AM on 03/27/17 while assigned to provide one-on-one coverage. Employee A was immediately removed from his one-on-one assignment and completed his shift in a different work location. The facility's decision was to reprimand Employee A, counsel him and to reassign him to a different shift. He remained employed at the facility.

Investigation A-17-02 (substantiated by the facility as abuse): on 06/24/17 at approximately 6:00 PM, an LPN alleged she heard Employee A say, "I'll break your back before I let you hurt another client." Employee A was placed on Administrative Leave on 6/24/17 although the exact time he was removed from duty was not recorded. On 10/23/18, at 3:45 PM, the Administrator confirmed Employee A was terminated from employment without ever returning to campus after 06/24/17.

Although Employee A was returned to duty after the confirmed allegation of neglect for sleeping on duty, the facility's decision to retrain him did not violate federal regulation. Once the allegation of verbal abuse was reported, Employee A was removed from duty, and terminated without returning to duty.

d. Investigation A-17-060 (substantiated by the facility as neglect): the facility substantiated Employee B provided an individual who was NPO (nothing by mouth) with a small amount of cookie dough to eat. On 10/05/17, the individual who ate the cookie dough reported to a facility nurse that Employee B had given him cookie dough to eat. The Nurse reported the allegation and Employee B was placed on Administrative Leave. The allegation was substantiated, and Employee B was re-trained on the individual's plan and returned to duty. As a corrective action, the facility identified that training related to individuals who were NPO needed to be revised and clarified which was accomplished. Employee B received training on the individual's dietary needs and training was provided to all direct support staff regarding what it meant to be NPO especially as it related to someone with a feeding tube.

Investigation A-17-065 (substantiated by the facility as abuse): the allegation, dated 10/30/17, stated Employee B used a blocking pad and pushed an individual into the wall and called him a derogatory name. Employee B was removed from duty on 10/30/17 although the exact time was not recorded. Employee records documented Employee B's last day on duty was 10/30/17.

Although Employee B was returned to duty after the confirmed allegation of neglect for giving an individual who was NPO cookie dough, the facility's decision to retrain rather than terminate did not violate federal regulation. Once the allegation of abuse was reported and confirmed by the facility, Employee B was removed from duty, and terminated without returning to duty.

e. Investigation A-17-026 (substantiated by the facility as neglect): While watching video tape during the conduct of a different investigation, a male employee was heard saying he, "swatted a client on his ass." The video tape showed Employee D was in the area and failed to report the comment as an allegation of abuse. Employee D received a written reprimand, was counseled and was provided additional training regarding reporting of abuse and neglect and returned to duty.

Although Employee D was returned to duty after the confirmed allegation of neglect for failure to report abuse, the facility's decision to retrain rather than terminate did not violate federal regulation.

f. Investigation A-17-052 (substantiated by the facility as neglect): at about 11:30 AM on 08/20/17, an individual was found to be unresponsive in his bed. 911 was called and upon the arrival of paramedics, police and the coroner, the client was declared dead. The Nampa Police Department and the coroner initiated an investigation of the cause of death.

While reviewing video footage of hallways and common areas of the home where the deceased individual lived, it was determined bed checks were not conducted in accordance with facility policy and in compliance with the individual's plan. The facility substantiated neglect against Employee F and Employee G for failure to conduct bed checks in compliance with policy.

The facility changed procedures related to bed checks and Employee F and Employee G were subsequently retrained and returned to duty. The facility's decision to retrain rather than terminate Employee F and Employee G did not violate federal regulation. The police investigation did not result in the pursuit of criminal charges against any employee.

g. Investigation A-17-066 (substantiated by the facility as abuse): on 11/02/17, Employee H was involved in a behavior incident involving an individual. During the altercation, it was determined Employee H used an unapproved hold resulting in pressure being applied to the individual's wrist. Employee H was placed on Administrative Leave on 11/02/17 although the exact time he went off duty was not documented. The investigation of the unauthorized hold was completed on 11/09/17 and the facility substantiated Employee H committed abuse by performing an unauthorized hold causing pressure on the individual's joint. The result of the investigation also identified that changes needed to be made to the individual's plan to provide greater specificity about the use of wrist restraint. Employee H was provided with verbal counseling, training on proper holds, and training related to the changes made to the individual's plan. Employee H was returned to duty on 11/09/17. Subsequently, Employee H voluntarily resigned and his last day on duty was 12/03/17.

The facility's decision to retrain rather than terminate Employee H did not violate federal regulation.

It could not be determined that the facility's decisions to continue to employ staff failed to comply with regulations related to abuse, neglect and mistreatment. Therefore, the allegation was unsubstantiated, and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As the allegation was unsubstantiated, 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, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,

NICOLE WISENOR, Supervisor
Non-Long Term Care

NW/pmt