



return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 12, 2015**. Failure to submit an acceptable PoC by **March 12, 2015**, may result in the imposition of civil monetary penalties by **April 1, 2015**.

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 both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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 **March 20, 2015 (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 **March 20, 2015**. A change in the seriousness of the deficiencies on **March 20, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 20, 2015** includes the following:

Mary Ruth Butler, Administrator  
February 27, 2015  
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Denial of payment for new admissions effective **May 13, 2015**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, 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 **August 13, 2015**, 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 Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., 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 **February 13, 2015** 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 noncompliance 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>

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

- BFS Letters (06/30/11)

Mary Ruth Butler, Administrator

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

This request must be received by **March 12, 2015**. If your request for informal dispute resolution is received after **March 12, 2015**, 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 Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser". The signature is written in a cursive, slightly slanted style.

LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor  
Long Term Care

LKK/dmj  
Enclosures

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

PRINTED: 02/24/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135065</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/13/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHABILITATION - MOUNTAIN VALLEY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>601 WEST CAMERON AVENUE KELLOGG, ID 83837</b>
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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	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the annual federal recertification and complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were: Sherri Case LSW, QIDP, Team Coordinator Rebecca Thomas RN Linda Hukill-Neil RN</p> <p>The survey team entered the facility on February 9, 2015 and exited on February 13, 2015.</p> <p>Survey Definitions: CNA = Certified Nurse Aide DON/DNS = Director of Nursing/Services LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment MG = Milligram TAR = Treatment Administration Record</p>	F 000	<p style="text-align: center;"><i>RECEIVED</i></p> <p style="text-align: center;"><i>MAR 16 2015</i></p> <p style="text-align: center;"><i>FACILITY STANDARDS</i></p> <p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation – Mountain Valley does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p>	
F 176 SS=D	<p><b>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</b></p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure a resident who wished to self-administer medication was assessed to be able to safely perform subcutaneous injections. This was true for 1 of 4 random residents (#16) observed during</p>	F 176	<p><b>F 176 Resident Specific</b> Resident #16 was assessed for proper self-administration of injecting insulin after set up by Licensed Nurse (LN). The Interdisciplinary Team (IDT) has reviewed and approved resident implementation. The Self Administration of Medication Assessment was completed, a physician's order obtained, and the care plan is updated. The Lovenox was discontinued on 2-23-15.</p> <p><b>Other Residents</b> The clinical management team has reviewed residents with a desire to self-administer medications and/or treatments. Additional</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Marybeth Butler* TITLE *Executive Director* (X8) DATE *3-12-15*

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 176	<p>Continued From page 1</p> <p>medication pass. The failure created the potential for medication errors if the resident was not competent to self administer the injections. Findings included:</p> <p>Resident #16 was admitted to the facility on 1/15/15 with multiple diagnoses including Diabetes Type II and pannus skin graft with necrotizing facitis.</p> <p>The resident's February 2015 recapitulation Physician orders and MAR documented, "...Lantus Solostar 100 units/ml...inject 24 units Sub-q [subcutaneous] every morning..." for diabetes;</p> <p>"...Novolog 100 units/ml...inject Sub-q per sliding scale...201-250= 5 units..." for diabetes; and "...Lovenox [Enoxaparin] 40 mg/0.4 ml SQ [subcutaneous] q [every] AM..." for pulmonary embolism and deep vein thrombosis prevention.</p> <p>On 2/10/15 at 8:43 AM, Resident #16 was observed as she administered 3 separate subcutaneous (SQ) injections into her abdomen. LN #1 was in attendance. After the administration of each medication, the resident activated the safety cap which covered the used needle, and then handed the syringe to LN #1 for proper disposal into the sharps container. The resident stated she had administered her 2 insulin injections for a very long time, prior to residing at the facility and she also had administered a blood thinner medication at home in the past, just not this one. The resident administered to herself: Enoxoparin 40mg/0.4ml, Lantus Solostar 100units/ml insulin 24 units, and Novolog 100 units/ml insulin 5 units.</p> <p>On 2/11/15 at 4:07 PM, the DNS stated each</p>	F 176	<p>assessments were completed as indicated. No other residents self inject medications.</p> <p><b>Center Systems</b> The Staff Development Coordinator (SDC) has educated the LN staff regarding self-medication policy, to include but not limited to,</p> <ul style="list-style-type: none"> <li>• residents who provide self injections in the presence of the LN</li> <li>• the completion of the assessment form,</li> <li>• obtaining a physicians' orders, and</li> <li>• adjustments to the care plan.</li> </ul> <p>The IDT has also been educated on reviewing the assessment for resident teaching needs and safety. Self medication review will occur with change of condition, and at least quarterly.</p> <p><b>Monitor</b> The MDS Nurses and/or designee will perform observation rounds, review staff practices, and review two residents identified as desiring self medication to determine who requires a self medication assessment one time a week for one month, then every two weeks for two months. Self medication assessments will be reviewed by the IDT as completed. The audit will be documented on the Performance Improvement (PI) monitor beginning the week of March 20. The Director of Nursing Services (DNS) is assigned oversight for sustained compliance. Any concerns will be addressed immediately and discussed with the IDT as indicated. The PI committee will review after 90 days and may adjust the frequency of monitoring, as it deems appropriate.</p>		

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F 176	<p>Continued From page 2</p> <p>resident who performed self administration of medications had a BIMS score usually of 13 to 15. The resident was instructed, observed, and assessed to be able to safely administer their medications and an assessment form was completed and part of the resident's record. The DNS stated in regards to Resident #16's Self Administration of Medications form, "She doesn't have one." The DNS said the resident should have documentation of the assessment but the process had not been completed.</p> <p>On 2/12/15 in the AM, the facility provided their Policy and Procedures for Patient Self-Administration of Medications. The Policy and Procedures documented: "...The Interdisciplinary Team in collaboration with the patient's attending physician determines the patient's knowledge regarding the use of the medication and has the ability to safely administer..."; "...patient is assessed to determine the patient's cognitive, physical, and visual ability to carry out the responsibility of administering their medication..."; and "...If the patient has been approved by the IDT and Attending Physician to self-administer medication, an order to self-administer medications is obtained. The physician's order should specify...any medication(s) to be self-administered including dose, frequency and route..." *Resident #16's current Physician orders did not include documentation for any self administered medications.</p> <p>On 2/12/15 at 4:00 PM, the Administrator and DNS were informed of the concern. There was no additional documentation provided.</p>	F 176	<p><b>Date of Compliance</b> 3-20-2015</p>	

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F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure care plans for the prevention of skin injuries were followed. This was true for 1 of 9 sampled residents (# 2). Failure to implement protective devices placed the resident at risk for bruises and skin tears. Findings include:</p> <p>Resident #2 was admitted to the facility on 7/31/14 with diagnoses that included Alzheimer's disease, anxiety and delusions.</p> <p>The resident's quarterly 1/18/15 MDS assessment documented the resident was severely cognitively impaired, totally dependent on staff for dressing, eating and toilet use and used a wheelchair for mobility.</p> <p>The resident's 1/22/15 care plan for skin integrity related to poor safety awareness included an intervention for a padded mat on the wall to decrease the risk of the resident "bumping/bruising" his/her skin.</p> <p>During observations on 2/10/15 at 10:00 a.m., 10:30 a.m., and 2/11/15 at 12:15 p.m. the</p>	F 309	<p><b>F 309</b> <b>Resident Specific</b> Resident #2 was assessed by the facility wound nurse and IDT for the necessity of the padded mat on her wall to decrease the risk of skin injuries. It was determined that the padded mat was no longer useful and was discontinued. The care plan and Kardex were updated.</p> <p><b>Other Residents</b> The clinical management team has reviewed resident care plans for accuracy, updating the care plan, and Kardex communication as indicated. Rounds validate that the care plan is implemented at the bedside.</p> <p><b>Center Systems</b> The SDC has educated facility staff regarding implementation of the care plan, to include but not limited to,</p> <ul style="list-style-type: none"> <li>• communication of resident changing needs,</li> <li>• observation of items that are no longer effective, and</li> <li>• assessment of changing needs.</li> </ul> <p>Stop-n-Watch is the communication tool completed by line staff and given to the nursing supervisor. The nursing supervisor then updates the care plan and corresponding Kardex to the identified needs. The Kardex then communicates the updates back to staff. Care plans are reviewed with change of condition and at least quarterly. Clinical management rounds are completed at least weekly to validate Kardex is implemented at the bedside.</p>		

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F 309	Continued From page 4 resident was observed in bed without a padded mat on the wall next to the bed.  On 2/12/15 at 8:40 a.m. the DON stated the physical therapist had recommended the padded mat on 1/22/15 to prevent skin injuries to the resident and it should be in place.  On 2/12/15 at 9:50 a.m. the resident was observed in bed with the padded mat on the wall next to the bed.  The Administrator and the DON were informed of the above concern on 2/12/15 at 4:00 p.m. The facility provided no further information.	F 309	<b>Monitor</b> The clinical management team will make rounds one time a week and review two residents care plan implementation for 3 months to validate the Kardex is implemented at the bedside. The audit will be documented on the PI monitor beginning the week of March 20. The Executive Director (ED) is assigned oversight for sustained compliance. Any concerns will be addressed immediately and discussed with the IDT as indicated. The PI committee will review after 90 days and may adjust the frequency of monitoring, as it deems appropriate.		
F 328 SS=D	<b>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</b>  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure oxygen therapy was accurately administered to residents. This affected 1 of 6 sampled residents (#7) with oxygen therapy. The	F 328	<b>Date of Compliance</b> 3-20-2015  <b>F 328</b> <b>Resident Specific</b> Resident #7's oxygen tank is observed at least three times per shift during days and evenings. The care plan was updated to reflect this adjustment. Clinical staff validate on rounds the tank has adequate oxygen. There have been no further issues.  <b>Other Residents</b> The clinical management team has reviewed residents with portable oxygen tanks twice per shift on days and evenings when the portable tanks are utilized. There have been no further issues.		

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F 328	<p>Continued From page 5</p> <p>deficit practice created the potential for harm if residents had a drop in oxygen saturations causing them to become anxious, confused and/or experience respiratory distress. Findings included:</p> <p>Resident #7 was readmitted to the facility on 8/5/14 with diagnoses including COPD (chronic obstructive pulmonary disease), obstructive chronic bronchitis, chronic total artery occlusion of extremities, and right lower limb amputation.</p> <p>The resident's February 2015 Physician orders and TAR documented an oxygen order, dated 2/9/15, for oxygen (O2) to be administered via nasal cannula (NC) at 2 liters continuous for COPD. The TAR contained nursing documentation that the resident's oxygen was administered at 2 liters continuously for all shifts.</p> <p>Resident #7's current Care Plan documented an intervention of, "Administer Oxygen via nasal cannula...as ordered," and "...Monitor for s/sx [signs/symptoms] of acute respiratory insufficiency: Anxiety, Confusion, Restlessness, SOB [shortness of breath] at rest, Cyanosis, Somnolence."</p> <p>On 2/9/15 at 10:05 AM and 2/10/15 at 10:25 AM, the resident was observed in her wheelchair with the O2 via NC on and the liter flow set at 2 liters from the portable oxygen tank.</p> <p>On 2/10/15 at 3:30 PM, the resident was observed in her room, seated in her wheelchair, and playing with her dog. The resident appeared to have oxygen being delivered at 2 liters via NC from a portable oxygen tank on the back of her wheelchair. The surveyor asked the resident if</p>	F 328	<p><b>Center Systems</b></p> <p>The SDC has re-educated nursing staff and therapists regarding oxygen use, to include but not limited to,</p> <ul style="list-style-type: none"> <li>• adequate supply in the portable tanks,</li> <li>• filling process to maximize tank capacity,</li> <li>• process to validate that the oxygen tank is holding the gas</li> <li>• the frequency with which to observe tank fill levels (twice per shift), and</li> <li>• monitoring of residents on oxygen for signs and symptoms of hypoxia.</li> </ul> <p><b>Monitor</b></p> <p>The DNS and/or designee will make rounds two times a day reviewing two residents oxygen administration for two weeks, then one time a day for two weeks, then two times a week for one month, then one time a week for one month to monitor portable oxygen tanks have an adequate amount of oxygen for resident use. The audit will be documented on the PI monitor beginning the week of March 20. The DNS is assigned oversight for sustained compliance. Any concerns will be addressed immediately and discussed with the IDT as indicated. The PI committee will review after 90 days and may adjust the frequency of monitoring, as it deems appropriate.</p> <p><b>Date of Compliance</b> 3-20-2015</p>	
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F 328	Continued From page 6 she could feel the oxygen in her nose and the resident responded that she didn't think so. The surveyor lifted the tank and the gauge registered empty. LN #3 came into the room and the surveyor asked her to check the tank and the resident's oxygen saturation. LN #3 stated, "Yes, the tank was empty." The CNA checked the resident's oxygen saturation without any O2 delivered and the resident's saturation fluctuated from 86% up to 91%. LN #3 changed the oxygen tubing from the portable tank to the room air concentrator.  On 2/10/15 at 4:01 PM, CNA #4 was interviewed regarding Resident #7's portable oxygen tank and the tank being empty. The CNA said when she comes on duty she receives report and then does a walk through and checks the residents she is assuming care for on her shift. CNA #4 stated, "I should have checked her tank." The CNA said since the resident was in her room, it was the CNA's responsibility to have changed the flow to the room concentrator.  On 2/10/15 at 4:28 PM, the DNS was interviewed regarding residents' oxygen therapy and the facility's policy. The DNS stated, "CNAs and LNs should check the tanks. The tanks should be checked shiftly" and "check the portable tanks whenever anyone takes them out of their room."  On 2/11/15 at 4:00 PM, the Administrator and DNS were informed of the concerns. No additional information was provided to resolve the concern.	F 328			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329			

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F 329	<p>Continued From page 7</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure clinical justification for duplicate therapy. This was true for 1 of 9 (# 8) sampled residents. The use of two antidepressant medications placed the resident at risk for unanticipated declines or newly emerging or worsening symptoms. Findings included:</p> <p>Resident #8 was admitted to the facility on 6/21/08 with diagnoses which included vascular</p>	F 329	<p><b>F 329</b> <b>Resident Specific</b> Resident #8's use of Trazodone and Cymbalta were re-reviewed by the resident's attending physician with input from the facility's psychoactive team, consultant pharmacist and consulting psychiatrist. Clinical justification for duplicate therapy with consideration of risks and benefits is clearly documented by the attending physician. The resident care plan is updated for monitoring of possible risks.</p> <p><b>Other Residents</b> The pharmacist consultant in conjunction with the clinical management team has reviewed residents with physicians' orders for duplicate psychoactive medications. Documentation by the physician has been validated as present and/or requested and received to support duplicate drug therapy. Evidence is present in the medical record that the physician believes the benefits of duplicate drug therapy outweigh the risks. Care plans have been updated as indicated.</p> <p><b>Center Systems</b> The SDC has re-educated social services and nursing staff regarding psychoactive drug use, to include but not limited to,</p> <ul style="list-style-type: none"> <li>• duplicate therapy for antidepressants,</li> <li>• required physician documentation of benefits of duplicate therapy that outweighs the risks, and</li> <li>• assessment for drugs in the same class regardless of the intended use of the medication.</li> </ul> <p>Psychoactive drug use is reviewed by the clinical management team on admission,</p>		

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NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHABILITATION - MOUNTAIN VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST CAMERON AVENUE KELLOGG, ID 83837		
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F 329	<p>Continued From page 8 dementia with depressed mood, unspecified myalgia and myositis.</p> <p>A 12/17/14 note from the physician documented the resident, "appears to be unhappy, irritable and uncomfortable....would suggest perhaps considering restarting the Cymbalta..." The note documented the resident was "only" on Trazodone.</p> <p>Note: The physician note did not document how the resident was uncomfortable or include justification for the duplicate therapy.</p> <p>The resident's 1/25/15 recapitulation Physician's Order documented the following orders: Trazodone 100 mg at bedtime for depression with a start date of 9/17/14 and Cymbalta 60 mg daily for pain management with a start date of 12/18/14.</p> <p>The Wolters Kluwer/Lippincott Williams &amp; Wilkins Nursing 2014 Drug Handbook, 34th Edition, classifies both Trazodone and Cymbalta as antidepressants.</p> <p>The resident's care plan for major depression diagnosis related to chronic debility, chronic pain, and fibromyalgia, initiated on 3/7/11, and revised on 1/9/15, documented, "Administer prescribed routine Anti-Depressant Drugs as ordered: Trazodone."</p> <p>The resident's care plan for mood problem/psychosocial well being deficit related to generalized anxiety disorder, history of depression, vascular dementia with memory loss and occasional thoughts of "being better off dead," initiated on 6/23/08 and revised on</p>	F 329	<p>within 14 days of admission, monthly, and with a change of condition. The pharmacist consultant audits duplicate therapy documentation monthly for scheduled reviews and initiates attending physician response as indicated.</p> <p><b>Monitor</b> The Social Service Manager, Case Manager, and/or designee will audit new admission charts, all new orders for psychoactive medications, and two records weekly for the first one month and one record weekly for the next two months to validate physician documentation of the benefits of duplicate drug therapy are present. Requests will be made to the physician as indicated with validation of physician documentation of the benefits of duplicate drug therapy on the medical record. The audit will be documented on the PI monitor beginning the week of March 20. The DNS is assigned oversight for sustained compliance. Any concerns will be addressed immediately and discussed with the IDT as indicated. The PI committee will review after 90 days and may adjust the frequency of monitoring, as it deems appropriate.</p> <p><b>Date of Compliance</b> 3-20-2015</p>		

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

PRINTED: 02/24/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/13/2015
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F 329	Continued From page 9 10/2/13, documented, "Administer routine Anti-Depressant medication: Cymbalta."  On 2/12/15 at 9:55 AM, the DNS stated the pharmacist had not made a recommendation for two antidepressants and the physician had not provided clinical justification for the use of duplicate therapy.  On 2/13/15 at 11:00 AM, the Administrator and DNS were informed of the above concern. A 2/16/15 fax from the pharmacist referred to the 12/17/14 physician note, stating Cymbalta "helped augment depressive treatment as well as treat underlying pain issues."	F 329			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to	F 431	<b>F 431 Resident Specific</b> The outdated bags of pre-mixed IV antibiotics and the outdated Dakins solution were destroyed for residents #16, #17 and #3 immediately after being brought to the facility's attention on 2-11-2015. In addition, the outdated bottles of ASA and Senna Syrup were immediately removed from the medication cart and destroyed on 2-11-2015.  <b>Other Residents</b> The clinical management team completed medication room/ refrigerators, central supply, and medication cart audits to validate no additional expired items were available for use. No additional items were identified.		

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F 431	<p>Continued From page 10 have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure expired medications were not available for administration to residents. This was true for 1 of 15 sampled residents (#3), 2 random residents (#s 16 &amp; 17), and any resident in the facility who may have received OTC (over the counter) Senna Syrup and Aspirin. The failed practice created the potential for decreased efficacy if residents received expired medications. Findings included:</p> <p>On 2/11/15 at 10:45 AM, during an inspection of a medication room, 2 medication carts, and a medication refrigerator with LN #2 in attendance, there were observations of expired medications being stored and the potential for the expired medications to be administered to residents.</p> <p>The medication room had a cupboard which contained for Resident #3 a bottle of Dakins Solution with a documented expiration date of 7/9/14. The medication refrigerator contained 4 IV (intravenous) bags of Ceftriaxone 1gm/50ml D5W</p>	F 431	<p><b>Center Systems</b> The SDC has re-educated LN staff to the drug and biological expiration dates, to include but not limited to,</p> <ul style="list-style-type: none"> <li>• importance of checking medications and solutions for expiration dates             <ul style="list-style-type: none"> <li>◦ upon resident discharge,</li> <li>◦ upon discontinuation of medication, and</li> <li>◦ monthly</li> </ul> </li> </ul> <p>Checklists have been redesigned to cover all areas of storage in the medication room and central supply areas.</p> <p><b>Monitor</b> The night nurse and/or the central supply clerk will complete the updated checklist, reviewing for expired medications and solutions one time a week for two months, then every two weeks for two months. The audit will be documented on the PI monitor beginning the week of March 20.</p> <p>In addition, the facility Omnicare Consulting Pharmacist and Omnicare Nursing Consultant will perform spot checks of the medication room and central supply for any expired medications and solutions during their respective monthly and quarterly visits.</p> <p>The DNS is assigned oversight for sustained compliance. Any concerns will be addressed immediately and discussed with the IDT as indicated. The PI committee will review after 90 days and may adjust the frequency of monitoring, as it deems appropriate.</p>	

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F 431	<p>Continued From page 11</p> <p>(5% Dextrose in water) for Resident #17 with a documented expiration date of 1/27/15 and 6 IV bags of Gentamicin 100mg/100ml NS (normal saline) with a documented expiration date of 1/30/15 for Resident #16. The medication cart stock contained an opened bottle of Senna Syrup with an expiration date of 12/14 and an opened bottle of Aspirin 325mg with an expiration date of 11/14.</p> <p>On 2/11/15 at 11:00 AM, LN #2 acknowledged there were medications which had expired. The LN stated, "I will get rid of them." LN #2 said the pharmacy does come into the facility to audit and restock medications. The pharmacy possibly would not be going through every cupboard and the stock supplies and the nursing staff ultimately would be responsible for checking for outdated medications and supplies.</p> <p>On 2/11/15 at 5:50 PM, the Administrator and DNS were informed of the expired medications. No additional documentation was provided to resolve the concern.</p>	F 431	<p><b>Date of Compliance</b> 3-20-2015</p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001520</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/13/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHABILITATION - MOU</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>601 WEST CAMERON AVENUE KELLOGG, ID 83837</b>
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C 000	16.03.02 INITIAL COMMENTS  The following deficiencies were cited during the State Licensure and complaint investigation survey of your facility.  The surveyors conducting the survey were: Sherri Case LSW/QIDP, Team Coordinator Rebecca Thomas RN Linda Hukill-Neil RN  The survey team entered the facility on February 9, 2015 and exited on February 13, 2015.	C 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation - Mountain does not admit that the deficiencies listed on the State Form exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
C 784	02.200,03,b Resident Needs Identified  b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F 309.	C 784	Refer to the Plan of Correction at F 309	
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered  iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F328 as it relates to care of residents receiving oxygen therapy.	C 788	Refer to the Plan of Correction at F 328	
C 821	02.201,01,b Removal of Expired Meds  b. Reviewing all medications in the	C 821	Refer to the Plan of Correction at F 431	

RECEIVED  
MAR 16 2015  
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Marybeth Butler</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>3-12-15</i>
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001520</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/13/2015</b>
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C 821	Continued From page 1  facility for expiration dates and shall be responsible for the removal of discontinued or expired drugs from use as indicated at least every ninety (90) days.  This Rule is not met as evidenced by: Refer to F431 as it relates to the disposal of expired medications.	C 821		
C 835	02.201,02,i Meds in Possession of Resident Limitations  i. No medication shall be in the possession of the patient/resident unless specifically ordered by the physician on the patient's/resident's medical record, and in no case shall exceed two (2) units of dosage. All such medications shall be individually packaged by the pharmacist in units of dose, labeled with the patient's/resident's name, unit of dose, and date of distribution. The charge nurse shall maintain an inventory of these drugs on the patient's/resident's medical record.  This Rule is not met as evidenced by: Refer to F176 as it related to Self Administration of Medications.	C 835	Refer to the Plan of Correction at F 176	



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

FILE COPY

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

February 27, 2015

Mary Ruth Butler, Administrator  
Kindred Nursing & Rehabilitation - Mountain Valley  
601 West Cameron Avenue  
Kellogg, ID 83837-2004

Provider #: 135065

Dear Ms. Butler:

On **February 13, 2015**, an unannounced on-site complaint survey was conducted at Kindred Nursing & Rehabilitation - Mountain Valley. The complaint was investigated in conjunction with the facility's Recertification and State Licensure survey conducted from February 9 through February 13, 2015.

The following observations were completed:

- Initial tour observations of residents receiving oxygen therapy and to see if any residents had unattended medications;
- There were five residents observed who received oxygen therapy;
- Observations of the smoking area and the residents who smoked;
- Observations of three licensed nurses as medications were passed; and,
- Staff response to the residents' call lights.

The following documents were reviewed:

- The medical records of five residents who received oxygen therapy;
- The medical record of the identified resident;
- The facility's grievance file from August 2014 to February 9, 2015;
- Resident Council minutes from August 2014 to February 9, 2015;
- The facility's Incident and Accident reports from August 2014 to February 9, 2015;
- The facility's nursing staff hours for August 15 through August 28, 2015;

- The June 2014 to August 2014 Quality and Performance Quarterly Report, which included 20 family interviews, 20 staff interviews, 20 residents' observations and 20 sample records reviews; and,
- The facility's policies and procedures for Oxygen Therapy, Patient Self Administration of Medications, Smoking and General Dose Preparation and Medication Administration.

The following interviews were completed:

- Eight residents were interviewed during the resident group interview regarding quality of care and quality of life concerns;
- Seven residents were interviewed regarding quality of care and quality of life concerns;
- Two family members were interviewed regarding quality of care and quality of life concerns;
- The Director of Nursing Services (DNS) and the Administrator were interviewed regarding various quality of care and quality of life concerns;
- A Social Worker was interviewed regarding various quality of care and quality of life concerns, which included the identified resident;
- Three licensed nurses were interviewed regarding the administration of medications; and
- Two licensed nurses and two Certified Nurse Aides (CNAs) were interviewed regarding oxygen therapy.

The complaint allegations, findings and conclusions are as follows:

### **Complaint #6636**

#### **ALLEGATION #1:**

The complainant stated that at approximately 7:20 p.m. on August 21, 2014, the identified resident was found with her oxygen cannula lying on the oxygen tank. The resident's lips and feet were black and her oxygen saturation was at 36%. The complainant also stated the identified resident's oxygen was set at 4 liters and the doctor's order was for 3 liters.

#### **FINDINGS #1:**

During the survey, two random residents and four sampled residents were observed receiving oxygen therapy as ordered. One sampled resident was observed with a portable oxygen tank that was empty.

The identified resident's medical record documented the physician's order for oxygen to be administered at 3 liters. The resident's Nursing Progress Notes also documented the resident's oxygen setting was on 3 liters.

Due to the observance of the empty oxygen tank, the allegation was substantiated and the facility was cited at F328. Refer to F328 for additional information.

**CONCLUSIONS:**

Substantiated. Federal and State deficiencies related to the allegation are cited.

**ALLEGATION #2:**

The complainant said the Administrator was notified that an incident report was completed by the CNA who assisted when the identified resident was found without her oxygen cannula in place and an oxygen saturation of 36% on August 21, 2014, around 7:20 pm. According to the complainant, the oxygen had been deliberately removed and two young girls were observed in the resident's room.

**FINDINGS #2:**

The Administrator completed a Grievance/Complaint Report on August 22, 2014, for the identified resident in behalf of the complainant. The incident took place on August 21, 2014, at approximately 7:20 pm. The facility did a complete and thorough investigation of the incident regarding the identified resident not having oxygen in place, the reported oxygen saturation reading of 36%, the oxygen being deliberately removed and the presence of two unidentified girls in the resident's room.

There was no incident report completed on August 21, 2014. The identified resident's Nursing Progress Notes had no mention of any incident or concerns regarding the resident on the evening of August 21, 2014. An interview with the identified CNA revealed a report was not made on the evening of August 21, 2014, as the CNA did not feel the circumstances were unusual. The CNA stated the identified resident had been taken outside to smoke numerous times throughout her stay by a family member. The resident would return from smoking, short of breath and have blue tinged fingers and lips. The CNA remembered the identified resident did not have the oxygen in place on the evening of August 21, 2014, when he/she responded to the call light, but the resident would have removed the oxygen to go out to smoke. The CNA placed the oxygen tubing in the resident's nares and the room air concentrator was already on and set to 3 liters. The CNA had the licensed nurse come to assess the resident since she was feeling short of breath. The CNA stated the resident was not showing signs or symptoms of respiratory distress. There was no recorded oxygen saturation of 36% nor did the CNA remember the resident's saturation having ever been that low or he/she would have been concerned. The CNA stated there were no young female visitors in the room that night or any night that he/she had seen.

The facility was observed to welcome and have their residents' families present throughout the survey. There were no reports, grievances or concerns documented of children tampering with equipment or personal belongings in any of the residents' rooms. The identified resident, who

was no longer at the facility, had been in a room by herself. Interviews with the Social Worker, DNS and CNAs had not revealed the resident had any young children visit, and they had never seen children in his/her room.

After review of the identified resident's medical record and the Grievance/Complaint investigation, there was no evidence that the facility did not follow the proper procedures. This allegation was unsubstantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #3:**

The complainant reported there were high blood pressure medications found under the identified resident's bed.

**FINDINGS #3:**

The identified resident's medical record documented she was alert and oriented. The resident's physician ordered Metoprolol Succinate 50 mg to be administered twice a day for high blood pressure. The resident had not been approved by the Interdisciplinary Team and her physician to self-administer any of her medications.

On February 9, 2015, at 10:05 a.m., the surveyors made observations of 60 residents' rooms and did not see any medications on the floor or unattended medications. During the survey process, three licensed nurses were observed as medications were administered to the residents. The nurses remained in the residents' rooms until the medications had been consumed.

The allegation of high blood pressure medications being found on the floor could not be substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #4:**

The complainant reports that staff do not respond to the identified resident's call light.

**FINDINGS #4:**

The identified resident was alert and oriented. The resident was able to ambulate short distances with a front wheel walker and self-propel in the wheelchair. The identified resident's medical

Mary Ruth Butler, Administrator  
February 27, 2015  
Page 5 of 5

record documented that staff responded to the resident's call light frequently. The identified resident had been assessed to be independent with smoking outside. The identified resident had a family member in the room daily from early morning to late at night.

A group interview with eight residents, seven individual interviews and two family interviews revealed satisfaction with the staff and response time for the call lights. The June 2014 to August 2014 Quality and Performance Quarterly Report, which included 20 family interviews, 20 staff interviews, 20 residents' observations and 20 sample records reviews reflected resident and staff satisfaction with the facility at 100%.

The facility's grievance file documented this complaint as the only one filed during this time.

The Resident Council minutes documented there were no concerns with call lights or shortage of staff.

The allegation was unsubstantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option #2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor  
Long Term Care

LKK/dmj