



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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September 22, 2015

Rick Holloway, Administrator
Kindred Nursing & Rehabilitation - Caldwell
210 Cleveland Boulevard,
Caldwell, ID 83605-3622

Provider #: 135014

Dear Mr. Holloway:

On **September 11, 2015**, a survey was conducted at Kindred Nursing & Rehabilitation - Caldwell 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 one that comprises a pattern 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.

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 October 2, 2015. Failure to submit an acceptable PoC by **October 2, 2015**, may result in the imposition of civil monetary penalties by **October 2, 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 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*.

Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **October 27, 2015**. A change in the seriousness of the deficiencies on **October 27, 2015**, may result in a change in the remedy.

If you do not achieve substantial compliance within three (3) months after the last day of the

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survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions. This will be **December 11, 2015**. [42 CFR §488.417(a)]

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 11, 2016**, 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 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 **September 11, 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 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>

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

- BFS Letters (06/30/11)

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

This request must be received by **October 2, 2015**. If your request for informal dispute resolution is received after **October 2, 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 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 cursive script that reads "Nina Sanderson LSW".

NINA SANDERSON, L.S.W., Supervisor
Long Term Care

NS/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/11/2015
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - CALDWELL			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator Brad Perry, BSW, LSW Linda Hukill-Neil, RN Kendra Deines, RN</p> <p>The survey team entered the facility on September 8, 2015 and exited on September 11, 2015</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DDCO = District Director of Clinical Operations DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MD = Maintenance Director MDS = Minimum Data Set assessment PRN = As Needed</p>	F 000			
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's</p>	F 157		10/13/15	

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

TITLE

(X6) DATE

Electronically Signed

09/29/2015

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 157	<p>Continued From page 1</p> <p>physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to notify the family of 1 of 15 sampled residents (Resident #15) of changes in the resident's fluid consistency orders. The failure created the inability for the resident's guardian to contribute to the resident's health care decisions.</p> <p>Resident #15 was admitted to the facility on 9/10/14 with multiple diagnoses including multiple sclerosis.</p>	F 157	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Health & Rehabilitation - Caldwell does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form</p>		

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F 157	<p>Continued From page 2</p> <p>A Speech Therapy note, dated 5/14/15, documented a thin liquids trial was completed. The trial started on 5/7/15, to attempt to upgrade the resident's liquid consistency from nectar thick to thin. The trial was successful and on 5/12/15 an order was written to upgrade the resident to thin liquids. On the order form, the "family notified" space was blank. The speech therapy note did not document the notification of family.</p> <p>A plan of care note documented a meeting with the resident's family member on 5/13/15 to discuss communication and information sharing between the resident's clinics and the facility. The note did not specify if the ordered liquid consistency change from 5/12/15 was discussed.</p> <p>On 9/11/15 at 8:30 a.m., the DON stated she did not know if the family was notified of the upgrade in fluid consistency.</p>	F 157	<p>the basis for the deficiency.</p> <p>Resident Specific Resident #15 was discharged on 05/21/15 from the center.</p> <p>Other Residents The clinical management team reviewed other residents for graduation from therapy programs. Families were notified of improvements as indicated.</p> <p>Facility Systems Licensed Nurses and therapists are educated on hire to notify families/responsible parties of changes in resident condition. Re-education was provided by the Director of Nursing Services (DNS) to include but not limited to, residents who improve in therapy and/or graduate. The system is amended to include review of therapy order changes in morning clinical meeting. The case manager will validate that documentation shows evidence of family update regarding changes. Any concerns will be addressed by the Case Manager or assigned to a staff member for family notification follow-up. Interdisciplinary (ID) team validation will occur the next business day in morning clinical meeting.</p> <p>Monitor The Case Manager and/or designee will monitor 2 changes in therapy orders for family/responsible part notification, if available, weekly for 12 weeks. Starting the week of October 5, the review will be documented on the PI audit tool. Any</p>		

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F 157	Continued From page 3	F 157			
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to uphold the dignity of 1 of 15 sampled residents (Resident #13) when the resident was in distress and assistance was not provided after flies landed on the resident's face during the lunch meal service.</p> <p>Resident #13 was admitted to the facility 8/14/14 with multiple diagnoses including rheumatoid arthritis and depression.</p> <p>The resident's September 2015 psychotropic medication care plan documented the resident had episodes of verbal outbursts and disruptive tearful wailing due to psychosis. It documented the interventions for this behavior included determination of the underlying cause and provide positive interaction.</p> <p>On 9/9/15 at 12:15 p.m., the resident was observed at the lunch meal service. She was seated by herself at an individual table. The</p>	F 241	<p>concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Resident Specific The ID team reviewed resident #13. Timely dining assistance was evident on subsequent observation rounds. No flies were observed.</p> <p>Other Residents The ID team reviewed other residents in the dining rooms, evidence of timely assistance was observed. The electronic restaurant style ultraviolet fly trap located on the wall just outside the dining room, was serviced and found to be functioning effectively.</p> <p>Facility Systems Nursing staff are educated to provide timely assistance to residents in the dining rooms. Re-education was provided by the DNS to include but not limited to, elimination of flies prior to meal service, timely assistance, and intervention when</p>	10/13/15	

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F 241	Continued From page 4 resident was observed to have contracted fingers on both hands, and struggled to pick her hamburger. Two flies buzzed around her head and landed on her face. The resident started to cry and tried to swat the flies away, but was unsuccessful. The resident was not assisted until approximately 7 minutes later when she yelled for help. On 9/11/15 the DON was informed of the observation and agreed it would have been difficult for the resident to swat at the flies given the circumstance.	F 241	observance of resident frustration occurs. The restaurant style ultraviolet fly traps are included on the preventative maintenance plan. The system is amended to include observation of the dining rooms prior to meal service. If flies are present, they will be eliminated prior to resident entry for meals. Licensed Nurse Supervisor will validate dining room is free of flies and residents receive timely assistance on rounds. To prevent fly entry, the center is investigating the availability of air shields over the exterior doors close to the dining and kitchen areas. Monitor The Culinary Services Manager (CSM) and/or designee will monitor meal service for fly elimination and timely staff assistance for residents requiring help two times per week for 12 weeks. Starting the week of October 5, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280		10/13/15	

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F 280	<p>Continued From page 5</p> <p>within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, it was determined the facility failed to revise care plans for 3 of 13 (#s 1, 3 & 10) sampled residents. The care plans: *Were not revised when diabetic shoes were no longer used for Resident #1; *Did not document Resident #10 had oxygen; and, *Did not identify what Physical Behaviors and interventions were in place for Resident #3. This had the potential to result in harm if residents did not receive appropriate care due to lack of direction in their care plans. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 8/28/14 with multiple diagnoses including type 2 diabetes.</p> <p>The resident's Physical Mobility care plan documented a 11/18/14 intervention of, "P[atien]t is also to have diabetic shoes on when in w/c [wheelchair]..."</p>	F 280	<p>Resident Specific The clinical management team reviewed ζ Resident #1 - diabetic shoes were evaluated and they are no longer a benefit. The care plan was updated with removal of the shoes. ζ Resident #2 - continues to require oxygen. The care plan was updated with the addition of oxygen via nasal cannula. ζ Resident #3 - care plan was updated to include the specific behaviors of striking out unprovoked, kicking, and refusing food/fluids/medications.</p> <p>Other Residents The ID team reviewed other residents for needed revisions/updates to the care plan. Adjustments have been made as indicated.</p> <p>Facility Systems ID team and Licensed Nurses are</p>		

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F 280	<p>Continued From page 6</p> <p>During multiple observations from 9/8 to 9/10/15, the resident did not have diabetic shoes on when he was in his wheelchair.</p> <p>On 9/11/15 the DON stated the intervention was no longer in place and should have been taken off the care plan.</p> <p>2. Resident #10 was admitted to the facility on 2/4/15 with multiple diagnoses including a history of hypoxemia (oxygen deficiency).</p> <p>The resident's 2/4/15 Physician's Order documented the resident was to receive oxygen at 2 liters continuous via nasal cannula. Refer to F328.</p> <p>The resident's current care plan did not indicate the resident had oxygen.</p> <p>On 9/10/15 at 11:43 AM, the resident was observed in the dining room, in his wheelchair with a portable oxygen tank set at 2 liters.</p> <p>On 9/11/15 at 8:15 AM, the DON was asked if the resident had an oxygen care plan. She reviewed the care plan and said she could not find where oxygen was addressed.</p> <p>3. Resident #3 was admitted to the facility on 12/15/15 and on 5/11/15 with diagnosis which included unspecified psychosis and senile dementia with delusional features.</p> <p>Record review of the resident's Physical Mobility care plan, initiated 5/26/15, documented goals the resident would verbalize understanding of the need to control physically aggressive behavior, and would not harm himself or others.</p>	F 280	<p>educated to revise/update care plans with a change of condition and order changes. Re-education was provided by the DNS to include but not limited to, use of special shoes/footwear, oxygen use for chronic and/or acute conditions, resident specific method of manifesting behaviors, and specific staff interventions when those behaviors are manifested. The system is amended to include review of change of condition and order changes in morning clinical meeting. Care plan revisions will be validated. If the care plan is incomplete, the care plan will be updated and/or a staff person assigned to educate the staff responsible and update the care plan. New admission resident records will be reviewed on/or around 7 and 21 days for comprehensive care planning.</p> <p>Monitor The DNS and/or designee will audit 2 resident care plans for revision with change in orders and/or condition weekly for 12 weeks. Starting the week of October 5, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 280	Continued From page 7 Interventions included to administer and monitor the effectiveness of medications; analyze key times, places, circumstances, triggers and what de-escalates behavior; assess and anticipate the resident's needs for food, thirst, toileting needs, comfort level, body positioning and pain; and, offer as many choices as possible about care and activities. During multiple observations from 9/8 to 9/10/15, the resident was observed to be calm, and did not exhibit aggressive behaviors. On 9/10/15 at 1:25 PM, the DON was interviewed along with the DDCO. When asked what aggressive behaviors the resident exhibited, the DON stated the resident would hit, kick and refused to eat or take his medications. The DON stated these specific behaviors along with individualized interventions should have been care planned.	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, it was determined the facility failed to ensure a resident had Prevalon boots on	F 309	Resident Specific The ID team reviewed resident #1. Observation shows prevalon boots in	10/13/15	

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F 309	<p>Continued From page 8</p> <p>at all times as per the care plan and orders. This was true for 1 of 13 (#1) sampled residents. This had the potential for more than minimal harm if the resident developed pressure ulcers to his heels. Findings included:</p> <p>Resident #1 was admitted to the facility on 8/28/14 with multiple diagnoses including dementia.</p> <p>The resident's September 2015 Order Summary Report (Recapitulation) documented an 8/29/14 order for, "Prevalon boots at all times."</p> <p>The resident's Skin Integrity care plan documented a 7/7/15 intervention of, "Prevalon boots to both feet at all times."</p> <p>The resident was observed in bed or his wheelchair without the boots in place on: -9/8/15: 2:35 PM, 3:40 PM, 4:25 PM and -9/9/15: 7:45 AM, 8:45 PM, 9:25 AM, 10:20 AM, 11:25 AM, 12:40 PM, 2:00 PM.</p> <p>On 9/8/15 at 2:35 PM, CNA #1 and CNA #2 were observed to transfer the resident in a mechanical lift from his wheelchair to his bed. The resident was observed to have socks and no boots on prior to the transfer. After the resident was in bed, the two CNAs discussed with each other if the resident was still using the Prevalon boots, but were not observed to check the resident's care plan and did not put the boots on his feet.</p> <p>On 9/9/15 at 11:25 AM, the resident was interviewed regarding the boots. When asked if he had worn the boots before, he said he had. When asked if staff had asked him if he wanted to use the boots that day, he said, "No."</p>	F 309	<p>place on subsequent rounds. An additional pair is available when they need laundering. As indicated in the CMS-2567 the prevalon boot directives were on the care plan/kardex.</p> <p>Other Residents The ID team reviewed other residents on rounds that are care planned for prevalon boots. Residents had boots in place and staff could verbalize resident care needs and/or know the care plan/kardex resource.</p> <p>Facility Systems Nursing staff are educated to implement the resident care plan/kardex. Re-education was provided by the DNS to include but not limited to, use of prevalon boots. The system is amended to include licensed nurse validation of care plan implementation for residents during med pass. Surveillance audits to validate that nursing assistants know the care requirements of the residents and/or the care plan/kardex resource.</p> <p>Monitor The DNS and/or designee will audit residents with prevalon boot use for evidence of implementation 3 times per week for 4 weeks, then weekly for 8 weeks. Starting the week of October 5, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12</p>		

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F 309	Continued From page 9 On 9/10/15 at 2:35 PM, the residents heels were observed and appeared pink and intact. On 9/11/15 at 8:10 AM, the DON was interviewed about the boots. She said staff should have referred to the resident's care plan and placed the boots on his feet.	F 309	weeks, as it deems appropriate.		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interview, it was determined the facility failed to ensure showers and/or baths were consistently provided for 6 of 13 residents (#s 1, 2, 5, 9, 11, & 12) reviewed for ADL assistance. This deficient practice had the potential for more than minimal harm if residents experienced rashes, skin issues and/or unpleasant odors due to not being bathed regularly. Findings included: 1. Resident #12 was readmitted to the facility on 11/27/14 with multiple diagnoses including hemiplegia and hemiparesis. The resident's ADL Care Plan documented a bath 2 times a week and as needed, with 1 person assist.	F 312	Resident Specific The ID team validated resident #1, 2, 5, 9, 11, and 12 had bathing needs provided. Subsequent observations showed bathing provided. Medical records were not adjusted as legally no retroactive changes can be made. Other Residents The ID team reviewed other residents for bathing needs being met. Adjustments have been made as indicated. Facility Systems Nursing staff are educated to provide good personal hygiene through bathing at least twice weekly. Re-education was	10/13/15	

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F 312	<p>Continued From page 10</p> <p>Resident #12's 9/2015 ADL Flow Sheet documented the resident did not receive a bath from 9/2/15 until 9/10/15.</p> <p>On 9/10/15 Resident #12 stated he had not had a bath or shower for over a week now. The resident said he was embarrassed of how greasy his hair looked and that he probably smelled.</p> <p>On 9/11/15 CNA #3 stated the resident's bathing record reflected he had not received a bath or shower for 8 days.</p> <p>2. Resident #5 was admitted to the facility on 5/21/13 with multiple diagnoses including dementia and psychosis.</p> <p>The resident's ADL Care Plan documented the resident was to receive a bath twice weekly.</p> <p>Resident #5's 9/2015 ADL Flow Sheet documented the resident did not receive a bath from 9/1/15 until 9/9/15.</p> <p>On 9/11/15 at 8:55 AM, CNA #3 stated the resident's bathing record reflected she had not received a bath or shower for 8 days.</p> <p>3. There were similar findings in the lack of consistent bathing for Resident #11.</p> <p>4. Resident #1 was admitted to the facility on 8/28/14 with multiple diagnoses including dementia.</p> <p>The resident's 7/23/15 quarterly MDS assessment documented the resident was totally dependent on one person assistance with bathing.</p>	F 312	<p>provided by the DNS to include but not limited to, addressing documentation of bathing, management of resident refusals with plans for reapproach. The system is amended to include a new bathing schedule which is reviewed daily by the licensed nurse supervisor for implementation. Residents who do not have documented evidence of receiving the assigned bath will have a ¿stop-n-watch¿ communication tool completed by the bath aide explaining the action taken and the licensed that was informed. The licensed nurse will assist the bath aide with seeking compliance with bathing. Repeat attempts and alternate plans will be documented in the medical record. Stop-n-watch communication tools will be reviewed daily in morning clinical meeting.</p> <p>Monitor The DNS and/or designee will audit resident¿s bathing records and stop-n-watch tools for consistent bathing and documentation, to include refusals and re-approaches as indicated 3 times a week for 4 weeks, then weekly for 8 weeks. Starting the week of October 5, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 312	<p>Continued From page 11</p> <p>The resident's ADL care plan documented a 1/22/15 intervention of, "[Resident #1] is totally dependent on staff to provide a bath 2 times a week and as necessary."</p> <p>Record review revealed the resident did not receive a bath between 9/1/15 and 9/10/15.</p> <p>On 9/11/15 CNA #3 reviewed the resident's shower documentation and said it appeared the resident had not had a shower from 9/1 to 9/10/15.</p> <p>5. Resident #2 was admitted to the facility on 11/17/14 and 2/23/15 with diagnoses which included major depression and general anxiety.</p> <p>The 11/17/14 Skin Integrity Care Plan, documented an intervention, initiated 1/18/15, to bathe the resident three times a week and PRN.</p> <p>Review of the resident's bathing schedule for the months of July, August and September of 2015, documented the resident received one bath from 7/9 through 7/15, and one bath from 8/27 through 9/2. The bathing schedule documented the resident did not have a bath from 8/19 through 8/25 or from 8/30 through 9/8.</p> <p>During multiple observations on 9/8/15, the resident was observed to have greasy hair.</p> <p>On 9/10/15 at 2:30 PM, the DON stated the resident should have been bathed 3 times a week.</p> <p>6. Resident #9 was admitted 9/10/14 with multiple diagnoses including dementia.</p>	F 312			

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F 312	Continued From page 12 The resident's ADL Care Plan documented the resident required one staff participation with bathing. The resident's weekly bathing schedule was not documented in the care plan. The resident's September 2015 ADL Flow Record documented the resident received a tub bath on 9/1/15 and 9/9/15, with 9 days between baths. On 9/11/15, the DON stated the facility's standard for bathing was twice a week for each resident, and that the resident should have received one more bath in the 9 day period from 9/1/15 to 9/9/15.	F 312			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS 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 resident and staff interview, it was determined the facility failed to ensure residents received oxygen according to the physician's orders. This was true for 1 of 2 (# 10) residents sampled for oxygen	F 328	Resident Specific The clinical management team reviewed resident #10. Subsequent observation indicates his portable oxygen tank contains liquid oxygen, cannula attached	10/13/15	

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F 328	<p>Continued From page 13</p> <p>and created the potential for residents to receive oxygen therapy contrary to physician orders. Findings included:</p> <p>Resident #10 was admitted to the facility on 2/4/15 with multiple diagnoses including dementia and a history of hypoxemia (oxygen deficiency).</p> <p>The resident's 2/4/15 Physician's Order documented the resident was to receive oxygen at 2 liters per minute via nasal cannula (NC) for pneumonia.</p> <p>On 9/10/15 the following observations were made:</p> <p>*11:43 AM- The resident was observed in the dining room in his wheelchair with a portable oxygen tank set at 2 liters per minute and with his NC in place;</p> <p>*1:45 PM- The resident was observed in his room in his wheelchair with his NC in place, but the oxygen tubing was disconnected from the tank; and,</p> <p>*2:05 PM- The resident was observed in his room in his wheelchair with the oxygen tubing connected, but the tank was set at zero liters. The resident was asked if he had trouble breathing, but the resident gave a nonsensical response.</p> <p>On 9/10/15 at 2:12 PM, LN #4 was asked to observe the resident. She checked his oxygen saturation level which was 96 percent. She then connected the tubing to the resident's room air concentrator and turned it on to 2 liters. She said the portable tank was set at zero and said it was out of oxygen as well. After a minute with the oxygen turned on she asked the resident if he could breath better and he said he felt better.</p>	F 328	<p>and in place, and liter flow is set as indicated.</p> <p>Other Residents The clinical management team reviewed other residents for appropriate use of the portable liquid oxygen system. Adjustments have been made as indicated.</p> <p>Facility Systems Nursing staff are educated to validate oxygen is in place for residents as indicated to include concentrators and portable liquid oxygen systems. Re-education was provided by the DNS to include but not limited to, licensed nurse validation of the oxygen administration process for their assigned residents, as well as those they observe during dining and/or activities. The system is amended to include licensed nurse supervisor validation of oxygen system administration at the beginning of each shift and after meals. If adjustments are required, the licensed nurse and nursing assistant performance will be addressed.</p> <p>Monitor The DNS and/or designee will review 5 residents on oxygen for implementation of oxygen orders weekly at various times of day for 4 weeks, then 2 weekly for 8 weeks. Starting the week of October 5, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12</p>		

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F 328	Continued From page 14 On 9/11/15 at 8:15 AM, the DON was interviewed. She said nurses were supposed to check the portable tanks to make sure they were connected and were full.	F 328	weeks, as it deems appropriate.		
F 458 SS=D	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, it was determined the facility failed to ensure rooms with multiple residents had at least 80 square feet of living space per resident. This affected 3 of 62 resident rooms (#s 111, 112 and 114) which did not meet the minimum requirement of 80 square feet per resident. This practice created the potential for residents to experience a loss of well-being. Findings included: - 2 residents were in room 111, which had 78.6 square feet per resident. - 2 residents was in room 112, which had 79 square feet per resident. - 2 residents were in room 114, which had 79.5 square feet per resident. On 9/11/15 at approximately 10:10 a.m., rooms 111, 112, and 114 were observed to meet the needs of the current residents in those rooms. The furniture in the rooms was arranged in a manner that provided for ease of access to the beds and closets.	F 458	Resident Specific Resident rooms 111, 112, and 114 were observed to meet the needs of the current residents in those rooms as noted in the CMS-2567. Other Residents No other current residents are affected. Facility Systems The center requests a continuation of the room size waiver for rooms 111, 112, and 114. The residents in these rooms have approximately 1 to 3 square feet less than the required 80 square feet per resident. Resident needs are evaluated prior to placement and quarterly to evaluate for potential crowding. Monitor The social worker monitors resident room placement, to validate resident needs are met. Any concerns will be addressed immediately and discussed with the PI	10/13/15	

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

PRINTED: 10/30/2015
FORM APPROVED
OMB NO. 0938-0391

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F 458	Continued From page 15 The facility had a room size requirement waiver for rooms 111, 112 and 114 which was granted on 5/20/14. This waiver was in effect until the next on-site survey. On 9/11/15 at 10:15 a.m., the Administrator stated the facility was again requesting a waiver for the room size requirement.	F 458	committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	

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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the State licensure survey of your facility. The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator Brad Perry, BSW, LSW Linda Hukill-Neil, RN Kendra Deines, RN	C 000		
C 405	02.120,05,e Meets Room Dimension Requirements e. Patient/resident rooms shall be of sufficient size to allow not less than eighty (80) square feet of usable floor space per patient/resident in multiple-bed rooms. Private rooms shall have not less than one hundred (100) square feet of usable floor space. This Rule is not met as evidenced by: Please refer to F-458 as it relates to room size for Rooms #111, #112 and #114.	C 405	Resident Specific See F458 Other Residents See F458 Facility Systems See F458 Monitor See F458	10/13/15
C 422	02.120,05,p,vii Capacity Requirments for Toilets/Bath Areas	C 422		10/13/15

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

09/29/15

Bureau of Facility Standards

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C 422	<p>Continued From page 1</p> <p>vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water.</p> <p>This Rule is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to maintain the minimum number of tubs or showers for licensed beds. This affected 13 of 13 (#s 1-13) sampled residents, and had the potential to affect all residents who resided in the facility. Findings included:</p> <p>The facility was licensed for 71 beds and had 62 residents who resided in the facility.</p> <p>State guidance at C-422 indicated, in part, "...there shall be at least one (1) tub or shower for every twelve (12) licensed beds..." Seventy-one licensed bed divided by 12 licensed beds equaled 5.916 or 6 tubs or showers.</p> <p>During the "General Observations of the Facility" on 9/10/15 at 8:20 a.m., the Maintenance Director accompanied the surveyor. The East tub room had one tub, the Spa room had one shower, and the West Bath had one shower. The number of tubs or showers in the facility totaled 3. The MD stated, "There are no other bathing facilities. We have portable showers which we can connect to the sink faucets."</p> <p>On 9/11/15 at 10:15 a.m., the Administrator and</p>	C 422	<p>Resident Specific No specific residents were indicated.</p> <p>Other Residents All residents in the center are affected.</p> <p>Facility Systems The portable bathing tub is requested as a waiver. This unit can be taken to patient rooms for those who do not want to and/or are unable to leave their rooms, or those requiring and/or requesting the whirlpool unit for their comfort and relaxation. For those residents preferring or requiring showering/bathing rooms there is a spa room with a tub and two shower rooms as indicated in the CMS-2567.</p> <p>Monitoring The Executive Director is responsible to oversee that the center has adequate bathing units to meet the needs of the residents who reside in the center. Any concerns will be addressed immediately and discussed with the PI committee.</p>	

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C 422	Continued From page 2 the District Director of Clinical Operations both said the facility was requesting a waiver of the tub and shower requirement.	C 422		
C 762	02.200,02,c,ii When Average Census 60-89 Residents ii. In SNFs with an average occupancy rate of sixty (60) to eighty-nine (89) patients/residents a registered professional nurse shall be on duty for each a.m. shift (approximately 7:00 a.m. - 3:00 p.m.) and p.m. shift (approximately 3:00 p.m. to 11:00 p.m.) and no less than a licensed practical nurse on the night shift. This Rule is not met as evidenced by: Based on review of a 3 week nursing schedule provided by the facility, it was determined the facility did not meet the State requirement for registered professional nurse (RN) coverage when the resident occupancy rate was between 60 and 89 residents for each of the days reviewed. Inadequate RN coverage had the potential to negatively affect all residents living in the facility. Findings included: Review of the 3 week nursing schedule for 8/16/15 through 9/5/15 for RN coverage on the Day Shift (approximately 7:00 AM to 3:00 PM) and the Evening Shift (approximately 3:00 PM to 11:00 PM) revealed the following: *8/22/15 - The charge RN worked 10:00 AM to 10:31 PM, but there was no RN coverage for the Day Shift hours of 7:00 AM to 10:00 AM. The resident census was 62. *9/3/15 - The charge RN worked 5:58 am to 3:09 PM, but there was no RN coverage for the	C 762	Resident Specific No specific residents were identified. Other Residents All residents in the center are affected. Facility Systems The center will continue to recruit additional Register Nursing (RN) staff, and if an instance occurs when the center census is 60 or greater and the RN staffing requirement cannot be met with current staff, the center will utilize agency RN coverage for the floor shifts. Alternately, if quality of care is compromised in any way from the use of agency staff, the center will voluntarily reduce its census to 59 or less until adequate RNs are hired to provide 16 hours of staffing daily.	10/13/15

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C 762	<p>Continued From page 3</p> <p>Evening Shift hours of 3:09 PM to 11:00 PM. The resident census was 62.</p> <p>On 9/11/15 at 8:45 AM, the Payroll Benefit Coordinator stated the DNS had worked both of those days and they had counted her hours as the charge nurse for the facility, in addition to her administrative duties.</p> <p>The facility failed to meet the requirement for 8 hours of RN coverage during the Day and Evening shifts and ensure the DNS's role was strictly nursing administrative duties, when the facility census was between 60 to 89 residents. The facility's Timecards were reviewed to confirm the lack of coverage on the identified dates.</p>	C 762	<p>Monitor</p> <p>The Executive Director will monitor RN schedules, RN hours as worked in the center, advertising campaigns to recruit additional RNs, agency RN staffing as needed, and validate that the DNS is not utilized as a floor nurse if the census is 60 or greater. Any concerns will be addressed immediately and discussed with the PI committee.</p>	



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
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December 8, 2015

Rick Holloway, Administrator
Kindred Nursing & Rehabilitation - Caldwell
210 Cleveland Boulevard
Caldwell, ID 83605-3622

Provider #: 135014

Dear Mr. Holloway:

On **September 11, 2015**, an unannounced on-site complaint survey was conducted at Kindred Nursing & Rehabilitation - Caldwell. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007057

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from September 8, 2015 to September 11, 2015.

The following observations were completed:

- Level of activity participation by residents;
- Level of alertness of residents during breakfast and dinner

Review of the following documents was completed:

- Gradual Dose Reduction forms from January to May 2015;
- Activity participation record from January to May 2015;
- Neurological assessments from January to May 2015;
- Physician notes from January to May 2015;
- Speech therapy notes in May 2015;
- Nursing notes from January to May 2015;

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- Signed physician orders from January to May 2015;
- Interdisciplinary Team notes from January to May 2015;
- Hospital record for the identified resident;
- Care plan with changes from January to May 2015;
- Weights from January to May 2015;
- Nutrition assessments from January to May 2015;
- Nutrition meeting notes from January to May 2015;
- Cardiac assessments in April and May 2015; and
- Vital signs in May 2015.

The following interviews were completed:

- The Director of Nursing interviewed regarding various quality of care concerns including concerns regarding communication with the Power of Attorney and sedation of the resident.
- The activity assistant was interviewed regarding the resident's participation in activities;
- Four other residents were interviewed regarding quality of care and quality of life concerns;
- One Registered Nurse was interviewed regarding sedation of the resident and weight concerns

Five other residents were reviewed for appropriate use of antipsychotic medications and two other residents were reviewed for weight loss/gain concerns.

Allegation #1: The complainant reported the resident was frequently oversedated on antipsychotic medications.

Findings #1: Residents in the facility were observed to be alert and actively participating in activities and cares; residents were alert during meals and able to feed themselves; the resident had appropriate physician visits and gradual dose reductions of anti-psychotic medication; the resident participated in activities; neurological assessments and nursing notes documented the resident was alert and appropriate; follow up assessments after increases in antipsychotic medications documented the resident was alert and unsedated; physician notes did not document oversedation or side effects due to antipsychotic medications; interviews revealed the resident was active in activities and cares in addition to interaction with staff and other residents.

Based on record review and staff interview, it was determined the allegation was unsubstantiated due to lack of evidence.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The complainant reported the facility failed to notify the family regarding a change in the ordered liquid consistency for the resident.

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Findings #2: Signed physician notes documented the resident's liquid consistency changed but did not document family notification; speech therapy notes, nursing notes, and IDT notes did not document notification of family.

Based on record review and staff interview, the allegation was substantiated at F-157. Refer to Federal 2567 report.

Conclusion #2: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #3: The complainant reported the facility oversedated the resident and changed the resident's liquid consistency, resulting in aspiration pneumonia and admission to a hospital.

Findings #3: The hospital record did not document a diagnosis of aspiration pneumonia.

Based on record review and staff interview, it was determined the allegation was unsubstantiated due to lack of evidence.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: The complainant reported the resident gained weight despite being on a weight loss plan, and this plan was not documented in the care plan.

Findings #4: The resident's nutrition assessment notes documented the resident's weight gain was due to edema and was stable; the nutrition meeting notes documented the resident was not on a nutritional weight loss plan, but had a goal to stabilize edema; the care plan documented appropriate nutrition, edema, and diet concerns with interventions.

Based on record review and staff interview, it was determined the allegation was unsubstantiated due to lack of evidence.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: The complainant reported the facility did not assess heart rate as ordered by the resident's Edema Clinic and instead recorded blood pressure.

Findings #5: The resident's cardiac assessments and vital signs in May 2015 documented pulse and blood pressure readings.

Based on record review and staff interview, it was determined the allegation was unsubstantiated due to lack of evidence.

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Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this 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 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,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large initial "D" and a clear "Scott" following.

DAVID SCOTT, Supervisor
Long Term Care

DS/pmt