July 22, 2016

Justin Polson, Administrator
Kindred Nursing And Rehabilitation-- Caldwell
210 Cleveland Boulevard
Caldwell, ID 83605-3622

Provider #: 135014

Dear Mr. Polson:

On July 7, 2016, an unannounced on-site complaint survey was conducted at Kindred Nursing And Rehabilitation - Caldwell.

The complaint was investigated on July 6 and 7, 2016. The resident identified by the Reporting Party no longer lived at the facility at the time of the complaint investigation.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007271

ALLEGATION #1:

The Reporting Party stated the facility worked short staffed and used Health Aides to provide resident care on March 5 and 6, 2016 on East Hall and East Center. Health Aides were not to provide care but to be "gofers" for the certified nurse's aides.

FINDINGS #1:

Observations made during the complaint investigation included the number of staff working on the East halls, staff care and treatment of residents, resident behaviors and residents displaying potential signs and symptoms of over-medication, including lethargy, decreased motor response, slow response to verbal stimulation, continuous sleeping, and poor food and fluid intake.
Interviews were conducted with three residents, two nurses aides, two certified nurses aides, two supervising nurses, two licensed medication nurses, the staff development coordinator, the acting director of nursing services, the facility administrator, and the facility's primary care physician.

Records reviewed included the identified resident's closed clinical record, as well as the medical records of three additional residents with similar behavior issues and medication use; staffing records for February and March 2016, as well as the three weeks prior to the complaint investigation; staff personnel records for employee evaluations, disciplinary actions, competency examinations and time frames for completion of Certified Nurses Aide certification; Grievance files; Resident Council minutes; Incident and Accident reports; and investigations for January through July 2016.

Based on observation, resident and staff interviews, review of staffing records and personnel files, it was determined facility staffing met regulatory requirements for all dates reviewed. All non-certified health aides used in the facility's core staffing were enrolled in a nurse aide certification program and were on schedule to complete certification within four months as required by federal regulation. The allegations could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The Reporting Party stated an identified swing shift caregiver would provoke an identified resident by standing in front of the resident and putting his/her hands up to startle the resident. This action agitated the resident who physically swung at staff and justified the administration of medication. This usually occurred on swing shift so the resident would be put to bed, relieving caregivers to monitor the resident's whereabouts.

FINDINGS #2:

Three residents who resided on the East halls were interviewed regarding observed or experienced mistreatment of residents by caregivers. Four direct care staff, two nursing supervisors, the staff development coordinator, the acting director of nursing, and the administrator were also interviewed regarding abuse protocol, including the reporting of abuse and whether any potential abuse issues had been observed or reported since January 2016. All residents and staff interviewed denied observing, hearing about, or experiencing resident mistreatment by staff. No actual or potential reports of staff mistreating residents were found in the Grievance files or Resident Council minutes.
Resident records were reviewed for behavior issues, facility and staff response to behaviors and the use of medications to address behavior issues.

The identified caregiver's personnel record was reviewed for employee evaluations, competencies, and disciplinary action.

Based on observations, resident and staff interviews, personnel record review and clinical record review, the allegation of staff mistreatment of the resident and the use of medications for the convenience of staff could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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,

David Scott, RN, Supervisor
Long Term Care

DS/lj