



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7007 3020 0001 4044 7403

March 27, 2013

Gerald Bosen, Administrator
Kindred Nursing & Rehabilitation - Weiser
331 East Park Street
Weiser, ID 83672

Provider #: 135010

Dear Mr. Bosen:

On **March 14, 2013**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Kindred Nursing & Rehabilitation - Weiser by the Department of Health & Welfare, 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 an isolated deficiency that constitutes actual 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, and a similar State Form 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.) **Please provide ONLY ONE completion date for each federal and state tag in column X5 Complete Date, to signify when you allege that each tag will be back in compliance.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION.

Gerald Bosen, Administrator
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After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 9, 2013**. Failure to submit an acceptable PoC by **April 9, 2013**, may result in the imposition of civil monetary penalties by **April 29, 2013**.

The components of a Plan of Correction, as required by CMS include:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- Include dates when corrective action will be completed in column 5.

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.

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- 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*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

Denial of payment for new admissions effective as soon as notice requirements can be met. [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 **September 14, 2013**, 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, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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 **April 9, 2013**. If your request for informal dispute resolution is received after **April 9, 2013**, 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, please contact us at (208) 334-6626.

Sincerely,

A handwritten signature in cursive script that reads "Loretta Todd".

LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj
Enclosures

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

PRINTED: 04/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/14/2013
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - WEISER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 EAST PARK STREET WEISER, ID 83672	
(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 recertification and complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Nina Sanderson, BSW LSW - Team Coordinator Linda Kelly, RN</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status BP = Blood Pressure CAA = Care Area Assessment CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS - Minimum Data Set POC = Plan of Care RAI = Resident Assessment Instrument Recap = Physician Recapitulation Orders TAR = Treatment Administration Record</p>	F 000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p style="text-align: center;">RECEIVED APR 24 2013</p> <p style="text-align: center;">FACILITY STANDARDS</p>	
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 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</p>	F 157	<p>F-157</p> <p>I. Identified Issue The facility had notified resident #2's physician prior to the start of the survey.</p> <p>II. Other Potential Issues The other residents who sustained falls have been reviewed and these reviews identified no issues with pain. The facility has verified physician notification for these falls.</p>	04/16/13

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

TITLE

(X6) DATE

Donald Bose

Executive Director

4/24/13

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>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 staff interview and record review, it was determined the facility did not notify a resident's physician of continued complaints of pain following falls. This was true for 1 of 5 (Resident #2) residents sampled for falls. The deficient practice had the potential to cause more than minimal harm when Resident #2's physician was not provided information to assess possible changes in the resident's clinical condition. Findings included:</p> <p>Resident #2 was admitted to the facility on 9/14/10 with diagnoses including history of motor vehicle accident with skull and nasal fractures, brain abscess, and craniotomy resulting in severe</p>	F 157	<p>III. Systemic Changes Licensed Nurses have been re-educated on notification of physicians for continued complaints of pain after a fall. Interdisciplinary Team (IDT) members to review all incidents for physician notification of changes in pain level.</p> <p>IV. Monitoring Director of Nursing (DNS) is responsible to oversee notification of physicians after all incidents. DNS or designee will review events for notification. Two to three fall events will be reviewed weekly for two months and then one event a week for one month. Findings of these reviews will be reported to the facility's Performance Improvement Meeting for trending and further recommendations.</p>		

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F 157	<p>Continued From page 2</p> <p>chronic seizure disorder; and intermittent falls and decreased ability to live independently.</p> <p>Resident #2 fell in the facility on 1/24/13, 2/3/13, 2/15/13, and 3/7/13. [NOTE: Please see F 323 as it pertains to falls. Please see F 309 as it pertains to pain and delay in treatment.]</p> <p>Following the fall on 2/3/13, Resident #2's PNs documented:</p> <p>-2/4/13 at 2:30 AM "...Cont to c/o [complain of] [right] shoulder pain. [Right] ice/heat therapy..." [NOTE: 5 hours, 45 minutes had elapsed since the time of the fall. There was no documentation of the effectiveness of the ice and heat implemented for Resident #2's pain. There was no documentation range of motion had been assessed for Resident #2's right arm. There was no documentation Resident #2's physician had been informed of the continued complaints of pain.]</p> <p>-2/4/13 at 4:15 PM, "Res [with] c/o [right] shoulder/arm pain today [related to] previous fall. Tylenol helpful [with] pain." [NOTE: 19 hours, 30 minutes had elapsed since the time of the fall. There was no documentation Resident #2's physician had been notified of Resident #2's continued complaints of pain. There was no documentation of range of motion being assessed on Resident #2's right arm.]</p> <p>-2/5/13 at 2:30 PM, "Res still [with] c/o [right] shoulder pain [related to] previous fall. [No] bruising visible. ROM adequate to [right] arm..." [NOTE: 29, hours 45 minutes had elapsed since Resident #2's fall. There was no documentation</p>	F 157			

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F 157	<p>Continued From page 3</p> <p>Resident #2's physician had been notified of continued complaints of pain.]</p> <p>-2/7/13 at 9:20 AM, Condition Change Form, "Res continues to c/o [right] shoulder pain. c/o [increased] pain [with] movement. Unable to raise arm above shoulder height this AM. [Right] shoulder and upper arm with edema." The form indicated Resident #2's physician was notified at this time. [NOTE: 3 days, 12 hours, 35 minutes had elapsed since Resident #2's fall. There was no documentation of Resident #2's pain levels or assessment of his range of motion documented in the PNs for 2/6/13.]</p> <p>On 3/12/13 at 4:30 PM, the DNS and DDCO were interviewed regarding Resident #2's fall, and the timing of the assessment of his continued complaints of pain before the fracture was diagnosed. The DNS stated she recalled discussions with the nursing staff regarding this issue. The DNS stated Resident #2 reported pain, but seemed to go about his normal daily routine, including ambulating and smoking, so the nurses did not feel the need to follow up with the physician.</p> <p>Following the fall on 2/15/13, Resident #2's PNs documented:</p> <p>-2/16/13 at 12:30 PM, "Resident has been complaining of severe pain in his [right] groin area since 0730 [7:30 AM] today, calls out in pain frequently. Resident cannot walk, requires two-assist for transfer. Temp 101.3 [degrees]. Resident was found sitting on floor on 2/15 PM shift. Groin [right] is tender to light palpation...Medicated for pain and fever X 2 with</p>	F 157			

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F 157	Continued From page 4 Norco, applied ice pack to groin. Informed [physician's name] via telephone about resident's condition at 1230 hrs [12:30 PM]. [Physician's name] stated that he can evaluate the resident on 2/17 Sunday, and directed me to ship resident to the ER [emergency room] if anything worsens..." [NOTE: 5 hours elapsed between the time Resident #2 complained of severe pain, and the time his physician was notified. There was no documentation of Resident #2's range of motion at the time of the onset of his pain complaints.] On 3/13/13 at 10:15 AM, the DNS was interviewed about physician notification for Resident #2's complaints of pain. The DNS stated when Resident #2 first complained of pain to the nurse on duty that day, the resident told the nurse it felt like a hernia. Based on that statement from the resident, the nurse felt it would be appropriate to treat with medications and ice to see if those interventions were helpful before notifying the physician. The DNS stated, "It didn't get documented." The DNS was asked if the physician should have been notified of the resident's pain complaints, regardless of the presumed cause. The DNS stated, "yes." The DNS was asked if the physician should be notified of a resident developing a hernia. The DNS stated, "yes." The facility offered no further information to resolve this concern.	F 157			
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.	F 164			

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F 164	Continued From page 5 Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure residents' privacy was maintained when subcutaneous injections were administered into the abdomen. This was true for 1 of 9 sample residents (#5) who received a medication by subcutaneous injection during a medication pass observation. The failed practice created the potential for a negative effect on the residents' psychosocial well-being related to privacy. Findings included:	F 164	F-164 I. Affected Residents Licensed Nurse #1 was re-educated regarding provision of privacy during insulin administration including latching the door and closing the window blinds. II. Other Residents Potentially Affected. Facility conducted random observations and identified no other issues during subcutaneous injection administration. III. Systemic Changes Licensed Nurses re-educated regarding providing privacy during subcutaneous Injection administration. IV. Monitoring The DNS is responsible to oversee that residents receive privacy during injection administration. DNS or designee will audit three injections a week for two months and then one injection a week for one month. Findings of these audits will be reported to the facility's Performance Improvement Meeting for trending and further recommendations.	04/16/13

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F 164	<p>Continued From page 6</p> <p>Resident #5 was originally admitted to the facility on 10/6/10, and most recently readmitted on 12/6/12, with diagnoses which included late effects of right cerebrovascular accident (CVA), left hemiparesis, and insulin dependent diabetes.</p> <p>The resident's most recent quarterly MDS assessment, dated 1/21/13, coded in part:</p> <ul style="list-style-type: none"> * Moderate cognitive impairment with a BIMS score of 11; * Adequate hearing and vision; * Able to understood others and to be understood by others; * Extensive assistance of 2 people for bed mobility; * Total dependence of 1 person for dressing; and * Injections for 7 of 7 days in the look back period. <p>During a medication pass observation on 3/12/13 at 11:40 a.m., Resident #5 was observed seated in her geri chair next to her bed. The resident's vertical window blind was open and an outside patio area was visible through the open slats of the blind. LN #1 informed the resident it was time for her noon dose of Lantus insulin and the resident agreed. However, the LN did not shut the window blind or close the door to the resident's room before she exposed the resident's abdomen and administered the medication into the resident's left lower abdomen.</p> <p>Immediately afterward, LN #1 was asked about the privacy issue. The LN stated, "Oh!" and acknowledged the resident's blind and room door were both open when she administered the insulin injection into the resident's abdomen. She added, "I did everything else right."</p>	F 164		

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F 164	Continued From page 7	F 164		
F 221 SS=D	<p>On 3/14/12 at 11:00 a.m., the Administrator, DNS, and Divisional Director of Clinical Operations were informed of the privacy issue. However, no other information was received from the facility.</p> <p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff and family interview, and resident review, it was determined the facility failed to determine how the presence of a lap tray would reduce the risk of an identified resident falling forward from his wheelchair, or how the lap tray would impact the resident at meals. This was true for 1 of 2 (Resident #4) residents sampled for restraint use. The deficient practice unnecessarily restrained the resident and had the potential to contribute to weight loss when the resident was not able to freely access his meals, and increased the risk of injury should the resident fall forward in the wheelchair with the lap tray attached. Findings included:</p> <p>Resident #4 was admitted to the facility on 5/1/12 with a diagnosis of Lewy body dementia.</p> <p>Resident #4's Annual MDS assessment, dated 2/18/13, coded: -Unable to complete the BIMS, assessed by staff with moderately impaired decision making skills.</p>	F 221	<p>F-221</p> <p>I. Identified Residents Resident #4 has been reassessed related to maintaining seated position in wheel chair and use of how the lap tray impacts the resident at meal times.</p> <p>II. Other Residents A facility review of residents revealed that there are no other restrictive devices in use.</p> <p>III. Systemic Changes Licensed nurses and Interdisciplinary Team (IDT) members have been re-educated regarding appropriate assessment of restrictive devices for safety and accommodation at meal times, when restraint initiated and ongoing assessment of use.</p>	04/16/13

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F 221	<p>Continued From page 8</p> <p>-Extensive assistance of two persons for transfers.</p> <p>-Limited physical assistance from one person to eat meals.</p> <p>-Has had two or more falls without injury since the last assessment.</p> <p>Resident #4's Falls CAA summary, dated 2/22/13, documented, "Res [with] fall hx [history]. Res unaware of safety [and] physical limitations d/t [due to] Lewy Body dementia. At high fall risk. Has seat belt/lap trap for safety..."</p> <p>Resident #4's care plan documented the following, under the problem area "Risk for Falls";:</p> <p>- "Seat belt while up in wheelchair d/t unaware of limitations d/t Lewy body dementia." Initiated 5/23/12, discontinued 3/11/13.</p> <p>- "Laptray to wheelchair R/T leaning forward in wheelchair (nonrestrictive). Use device safest for resident based on physical status." Initiated 9/25/12, changed 3/11/13.</p> <p>- "Restraint free time: bed, toileting, 1:1 [one on one attention], ambulation. Add laptray on w/c [wheelchair] at all times R/T [related to] unaware of abilities [and] leaning forward R/T Lewy body dementia. Add if res leaning in w/c or appears unsafe in w/c offer to lay down or place in recliner. If declines, place 1:1 [with] res until safe to be left alone." Initiated 3/11/13.</p> <p>An "Acknowledgment of Physical Restraint Use" form was in Resident #4's chart for the use of a lap tray while up in his wheelchair. The form did not document whether or not the lap tray had been assessed as safe for Resident #4. The form was signed by Resident #4's spouse on 5/31/12.</p>	F 221	<p>IV. Monitoring</p> <p>DNS is responsible to oversee the appropriate assessment of restrictive devices including safety and accommodation during meal times. DNS or designee will audit restraint assessments upon initiation and monthly for continued need. Audits will be continued indefinitely as long as there is a restraint in use. Findings of these audits will be reported to the Performance Improvement Meeting for trending and further recommendations.</p>		

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F 221	<p>Continued From page 9</p> <p>On 3/8/13 at 9:30 PM, a Post-Event Investigation/Interviews form for Resident #4 documented:</p> <p>-In the "Describe Event" areas of the form, "... [Resident #4] on all fours [with] the w/c still buckled to him. He denied any pain...He was set to right and table top restraint put on to keep him upright."</p> <p>-In the "What happened? area of the form, "[Resident #4] had been leaning over periodically throughout the evening and he apparently leaned too far and tipped his w/c over."</p> <p>Resident #4's "Resident Progress Notes" (PNs) documented:</p> <p>-3/8/13 Condition Change Form at 9:30 PM, "Resident found in hallway on all fours with w/c still attached no apparent injury [at] this time."</p> <p>-3/11/13 Condition Change Form at 11:45 AM, "Event Comm[ittee] F/U [follow-up]...Appears res busy therefore lap tray not appropriate as res had purposeful activity [with] leaning..."</p> <p>-3/11/13 Condition Change Form at 5:10 PM, "...Risks [and] benefits discussed R/T seat belt alarm on w/c [and] lap tray use. IDT concluded that d/t res fluctuations in ability [and] mood, laptray to w/c safest device for res. Will [change] res to lap tray [at] all times."</p> <p>On 3/11/13, an "Interdisciplinary Physical Restrain Evaluation" form for Resident #4 documented, " IDT record [and] CP [care plan] review [after] fall 3/8/13 [with] seatbelt on w/c [and] still attached to res. Res remains unable to process ability [and] leans in w/c [without] boundaries [and] safety awareness R/T Lewy Body Dementia."</p>	F 221			

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F 221	<p>Continued From page 10</p> <p>On 3/11/13 at 1:55 PM, Resident #4 was observed in his wheelchair in the lounge area near the south nurse's station. A seat belt was fastened around his waist.</p> <p>On 3/12/13 at 8:05 AM, Resident #4 was observed sitting in his wheelchair near the nurse's station. There was a full lap tray attached to his wheelchair. Resident #4 briefly looked at a newspaper, then reached back with his left hand to the left rear part of the lap tray, leaned forward with his upper body, and pushed up with his left arm as if to stand. LPN #2 quickly approached Resident #4 to assess his need, and Resident #4 was taken to use the bathroom.</p> <p>On 3/12/13 at 8:30 AM, Resident #4 was observed sitting in his wheelchair in the Willow Room. He was sitting in his wheelchair at the breakfast table. The lap tray was attached to the wheelchair as he ate his meal. The lap tray was positioned between Resident #4 and the table, but adjusted to a downward angle of 30-45 degrees. As Resident #4 attempted to eat his breakfast, the tray portion of the lap tray was positioned so it rested on the top of his knees. The arms of the lap tray were positioned so they were in his armpits. His breakfast meal was on the table, so that Resident #4 had to reach across his lap tray to access his food. Resident #4 was attempting to feed himself Cheerios, with his body in a leaning/bending position over the front of the lap tray. He was feeding himself with his right hand, and grasping tightly onto the corner of the table with his left hand, as if to keep himself positioned to reach his meal. There was no staff present in the room until 8:37 AM. At that time, the DNS approached the resident, cued him to</p>	F 221			

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F 221	<p>Continued From page 11</p> <p>eat his roll, and straightened his lap tray slightly. The tray was at a less awkward angle after the adjustment, but the resident was now further from the table and his meal. The DNS then left the room. The resident reached out with both hands, grasped the table, and pulled himself closer, forcing the lap tray into his knees, abdomen, and armpits as he did so. He continued to grasp the table tightly with his left hand, and began to drink his juice with his right hand. At 8:42 AM, Resident #4 released his grip on the table with his left hand, and his wheelchair moved backwards from the table approximately one foot. He was no longer able to reach the table. He used his fingers to pick crumbs off of his lap tray and eat them. At 8:46 AM, Resident #4 was approached by LPN #2 and cued to eat his roll. LPN #2 then left the room. Approximately 1 minute later, the Case Manager approached Resident #4 to inquire about his meal, then left the room. There was no offer to remove Resident #4's restraint to allow him to access his meal during either of these encounters.</p> <p>On 3/12/13 at 3:00 PM Resident #4 was observed sitting in his wheelchair in the lounge area near the nurses station. That same day at 5:15 PM, 5:32 PM, and 5:45 PM, Resident #4 was observed sitting in his wheelchair in the Willow Room. On all of these occasions, Resident #4 was leaning forward in his wheelchair against the lap tray, with his upper body, arms, and elbows positioned on the lap tray. The full weight of his upper body was on the lap tray. The front of the lap tray was forced into Resident #4's knees, and the back of the lap tray was forced into his armpits.</p>	F 221			

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F 221	<p>Continued From page 12</p> <p>On 3/12/13 at 5:46 PM, Resident #4's dinner meal was delivered to the Willow Room. Resident #4 was sitting across the room from his table. LPN #2 was present, asked Resident #4, "Can you sit up?" Resident #4 did not respond. LPN #2 then began to rub Resident #4's back to attempt to engage him. When Resident #4 again did not respond, the table was brought to where he was sitting. The lap tray was in place between Resident #4 and the table. Resident #4 briefly engaged with his meal, and LPN #2 left the room. At 5:55 PM, the Case Manager entered the Willow Room and helped reposition Resident #4's lap tray. After the adjustment, the lap tray was closer to and lower down on Resident #4's torso, so the lap tray would fit under the table. The lap tray was not removed. The case manager sat with Resident #4 for the remainder of the meal.</p> <p>On 3/13/13 at 10:25 AM, the surveyor informed the DNS and DDCO of the observations of Resident #4 leaning against the lap tray with his upper body, and whether or not the facility had assessed the risk of Resident #4 falling forward in his wheelchair with the lap tray still attached. The DNS stated in the past the facility had used the lap tray intermittently with the seatbelt for Resident #4 because of his fall history. The DNS stated that in general, the facility considered the lap tray to be more restrictive, but at times it was felt the seatbelt was not enough to keep Resident #4 safe. The DNS referred to Resident #4's fall on 3/8/13 as evidence the seatbelt was not effective. The DNS was asked how the lap tray addressed the circumstance of Resident #4's fall. The DNS stated the IDT had conversations regarding this resident on 3/11/13, the day the changes were made. The DNS stated other</p>	F 221			

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F 221	Continued From page 13 options had been considered, but ruled out because of the concern other problems would arise. However, the DNS was not able to describe how the lap tray was assessed to be a safe alternative for this resident, given his tendency to lean forward and try to stand from his chair. On 3/13/13 at 10:25 AM, the DNS and DDCO were also asked about the use of Resident #4's lap tray at meals. The DNS stated typically it would be the expectation that a restraint was released at mealtimes. However, the DNS stated the lap tray was new for this resident, and "We hadn't really talked about how it was going to work at meals." On 3/13/13 at 12:05 PM, Resident #4 was observed in the Willow Room eating his lunch. The lap tray had been removed, and the resident was able to access his meal without difficulty. Resident #4 was readily feeding himself his meal. On 3/13/13 at 6:15 PM, the Administrator, DNS, DDCO, and SDC were informed of these findings. The facility offered no further information to resolve the concerns.	F 221			
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246	F-246 I. Affected Residents Resident #2 is now eating his meals outside of his room.	04/16/13	

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F 246	<p>Continued From page 14</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, and record review, it was determined the facility did not provide adaptations to a resident's environment to ensure the resident could access his meals. This was true for 1 of 6 residents (Resident #2) sampled for environmental accommodations. This deficient practice had the potential to cause more than minimal harm if Resident #2 was unable to access his meals and became compromised nutritionally. Findings included:</p> <p>Resident #2 was admitted to the facility on 9/14/10 with diagnoses including history of motor vehicle accident with skull and nasal fractures, brain abscess, and craniotomy resulting in severe chronic seizure disorder; and intermittent falls and decreased ability to live independently.</p> <p>Resident #2's Change of Condition MDS, dated 2/28/13, coded: -BIMS of 4 (severely impaired cognitive skills.) -Extensive assistance of 2 persons for transfers. -Did not ambulate. -Extensive assistance of 2 persons for toilet use. -Able to eat with supervision after set-up.</p> <p>Resident #2's care plan, dated 2/26/13, documented:</p> <p>-Under the problem area for Nutrition, the approach, "Dines in: room per his choice encourage to attend meals in dining room." Onset date was documented as 12/15/10. -A hand written addition to the care plan for falls, dated 3/8/13, documented, "Floor mat alarm on when res in bed to alert staff of self-transfer."</p>	F 246	<p>II. Other Residents A facility review of other residents using alarmed floor mats by bedside revealed these residents are eating meals in dining room and are therefore not impacted.</p> <p>III. Systemic Changes Nursing Staff re-educated regarding use of alarmed floor mats as it impacts meal times for residents who eat meals from the edge of their beds.</p> <p>IV. Monitoring The DNS is responsible to oversee that alarmed floor mats are use appropriately. DNS or designee will monitor by observation rounds three times a week for one month then two times a week for two months. Findings of these observations will be reported to the Performance Improvement Meeting for trending and further recommendations.</p>	

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F 246	<p>Continued From page 15</p> <p>On 3/12/13 at 5:15 PM, Resident #2 was served his evening meal tray in his room. Resident #2 was laying supine in bed when the tray was delivered. Resident #2 then sat up on the edge of his bed to eat his meal. As his feet touched the floor mat alarm next to his bed, the alarm sounded and Resident #2 immediately responded to the alarm by laying back down in bed. Within approximately 5 minutes, Resident #2 sat up at the edge of his bed again to eat his meal. Again, as his feet touched the floor the floor mat alarm sounded. Resident #2 responded to the alarm by laying back down on his bed immediately. He then propped himself up on his left elbow, reached over his body with his right hand to access his meal tray, twisting his torso at the hips, and began to feed himself with his right hand. [NOTE: Resident #2 had a sling in place to immobilize the upper portion of his right arm due to a clavicle fracture.]</p> <p>On 3/13/13 at 10:15 AM, the DNS and DDCO were asked about Resident #2's meals. The DNS stated Resident #2 would typically sit at the edge of his bed to eat for a few minutes, then lay down for a rest period, then sit back up again to finish his meals. The DNS was asked about the floor mat alarm in conjunction with Resident #2's meals. She stated the floor mat alarm should not have an impact on Resident #2 for meals. The DNS was informed of the surveyor's observations of Resident #2's response to the floor mat alarm during the meal the previous evening, and whether or not the floor mat had been assessed as a barrier at meal times given Resident #2's reaction to it sounding. The DNS stated, "We didn't talk about how meals would go as part of</p>	F 246			

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F 246	Continued From page 16 the floor mat."	F 246			
F 280 SS=D	<p>On 3/13/13 at 6:15 PM the Administrator, DNS, DDCO, and SDC were informed of these findings. The facility offered no further information to resolve the concerns.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>A comprehensive care plan must be developed 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, staff interview, and record review, it was determined the facility did not update a resident care plan to accurately reflect his functional status related to his weight bearing restriction. This was true for 1 of 6 residents</p>	F 280	<p>F-280</p> <p>I. Affected Residents Resident # 2's care plan has been updated related to current weight bearing status.</p> <p>II. Other Residents A review of residents revealed no other residents with weight bearing restrictions at this time.</p> <p>III. Systemic Changes Nursing Staff and IDT members have been re-educated regarding updating the care plan of weight bearing restrictions.</p> <p>IV. Monitoring The DNS is responsible to oversee that resident care plans accurately reflect restricted weight bearing status. DNS or designee to review care plans upon new orders and monthly for restricted weight bearing. Reviews to be continued indefinitely unless deemed no longer appropriate by Performance Improvement committee. Findings of these reviews will be reported to the Performance Improvement Meeting for trending and further recommendations.</p>	04/16/13	

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F 280	<p>Continued From page 17</p> <p>(Resident #2) sampled for care plan revisions. The deficient practice had the potential to cause more than minimal harm if the staff caring for this resident were unsure how to assist him without further damaging his fractured pelvis.</p> <p>Resident #2 was admitted to the facility on 9/14/10 with diagnoses including history of motor vehicle accident with skull and nasal fractures, brain abscess, and craniotomy resulting in severe chronic seizure disorder; and intermittent falls and decreased ability to live independently.</p> <p>Resident #2's Change of Condition MDS, dated 2/28/13, coded: -BIMS of 4 (severely impaired cognitive skills.) -Extensive assistance of 2 persons for transfers. -Did not ambulate. -Extensive assistance of 2 persons for toilet use. -Frequently incontinent of bowel and bladder. -Almost constant pain level of 8, on a 0 to 10 scale.</p> <p>Resident #2's consultant physician's progress notes included: 2/16/13 Emergency Room Record, "X-rays of the right hip and...pelvis...showed pelvic fracture along the medial aspect of the right acetabulum...patient has a bed available at his care center for monitoring support mechanisms...he can remain at bed rest at that facility and have orthopedic consult on [sic] regarding the medial acetabular fracture on the right side..." 3/4/13 Orthopedic Consult, "Minimal weight bearing to [right] leg..."</p> <p>Resident #2's Physical Therapy Evaluation and</p>	F 280			

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F 280	<p>Continued From page 18</p> <p>Progress Notes documented: -2/20/13 evaluation, "...fractured [right] pelvic. He is non-wt-bearing on [right lower extremity]...sling mech lift (criss cross for toileting) effective...staff training to establish safe transfers to protect pelvic fx [and reduce] pain..." -2/20/13 - 2/17/13 Progress Report, "...Pt [patient] tolerating sling lift with criss cross for toileting better..." -2/27/13 - 3/13/13 Progress Report, "...3/4/13 [Orthopedic Physician's name] after reviewing x-rays stated [Resident #2's] pelvic fx is non-displaced. He [the physician] ordered 'minimal wt bearing' to [right lower extremity]..."</p> <p>Resident #2's care plan documented: -"Resident will use walker to independently ambulate safely" discontinued as an approach on 2/28/13 "d/t non-wt bearing status." -"Remind resident to use walker to ambulate at all times" listed as a goal, with an onset date of 1/7/2011. -"Impaired physical mobility r/t [right] clavicle fx and pelvic fx" added on 2/20/13, amended to include "r/t non-wt bearing status" on 2/28/13.</p> <p>The following additions were made to Resident #2's care plan of 2/28/13: -"Transfer with 1-2 assist depending on Res ability to participate." -"No ambulation until wt bearing status [change]."</p> <p>[NOTE: There was no update on Resident #2's care plan about "Minimal weight bearing", including what that meant and how the staff should assist the resident to ensure it was carried out. There was no direction on Resident #2's care plan about using a mechinal lift to use the</p>	F 280			

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F 280	Continued From page 19 commode. There were conflicting instructions as to whether or not resident should be ambulating.] On 3/13/13 at 10:15 AM, the DNS and DDCO were asked about care plan updates following Resident #2's fall on 3/7/13. The DNS stated the facility had implemented a floor mat alarm at Resident #2's bedside as a result of that fall. However, upon reviewing the care plan, thd DNS could not find that intervention on the care plan. On 3/13/13 at 3:25 PM, the Physical Therapist (PT) was asked about Resident #2's weight bearing status. The PT stated "minimal weight bearing" had no definition, but was direction given by the orthopedic physician due to the knowledge of Resident #2's history of non-compliance. The PT stated she had provided a detailed in-service to facility staff to cue Resident #2 verbally while tapping his right leg to remind him not to put too much weight on it. On 3/13/13 at 4:25 PM, The DNS and DDCO were asked about Resident #2's care plan. The DNS stated the care plan had previously not been updated to reflect all of the recent changes with Resident #2. The DNS stated she had now updated the care plan to ensure its accuracy. On 3/13/13 at 6:15 PM, the Administrator, DNS, DDCO, and SDC were informed of the surveyors findings. The facility offered no further information to resolve the concern.	F 280			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281			

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F 281	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy and procedure (P&P) review, it was determined the facility failed to ensure: a) an inhaled steroid medication was administered before an inhaled bronchodilator, which created the potential for reduced therapeutic benefits of the medications; and, b) a resident rinsed her mouth with water and spit out the water after inhalation of a steroid medication, which created the potential for the resident to develop an oral fungal infection. This was true during 1 of 10 medication pass observations and it affected Resident #7. Findings included: On 3/12/13 at 9:18 a.m., LN #2 was observed as she administered 1 puff of Advair 500/50, an inhaled corticosteroid medication, then 6 oral medications, then 1 inhaled capsule of Spiriva, a bronchodilator, to Resident #7. The resident's March 2013 recapitulation of Physician's Orders included the orders: * Advair Diskus (fluticasone propionate and salmeterol) 500/50 BID (twice a day) for COPD (chronic obstructive pulmonary disease) and to, "Rinse mouth with H2O [water] after use." * Spiriva (tiotropium) 18 micrograms (mcg) 1 capsule daily, also for COPD. a) Note: Perry & Potter, 7th Edition, 2010, in Clinical Nursing Skills & Techniques, documented on page 559, "...Drugs must be inhaled sequentially. If bronchodilators are administered with inhaled steroids, the bronchodilators should	F 281	F-281 I. Affected Residents Licensed nurse #2 was educated regarding importance of the resident spitting after rinsing following administration steroid inhaler medication. Licensed Nurse # 2 was also re-educated regarding administering a bronchodilator before administering a steroid inhaler as was the case with resident #7. II. Other Residents Facility review revealed no other residents with a steroid inhaler. III. Systemic Changes Licensed Nurses re-educated regarding proper administration of steroid inhalers and spitting after rinsing following use. Licensed Nurses also re-educated regarding proper sequencing of bronchodilator and steroid inhalers.	04/16/13	

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F 281	<p>Continued From page 21</p> <p>be given first in order to dilate the airway passages for the second medication."</p> <p>On 3/12/13 at 1:50 p.m., LN #2 was interviewed. When asked about the aforementioned observation regarding Resident #7's Advair and Spiriva, the LN indicated she did not know Spiriva was a bronchodilator. The LN stated, "I should have switched them and given the Spiriva before the Advair."</p> <p>In the morning on 3/14/13, the DNS was informed of the observation regarding Resident #7's Advair and Spiriva. At that time, the DNS was asked to provide the facility's policy and procedure (P&P) on inhaled medications.</p> <p>Later that morning, the DNS provided the P&P, Oral Inhalant Administration (Metered Dose Inhalers). The P&P included the following documentation: * "Rationale...If more than one type of inhaler is ordered, administer in the following sequence for maximum drug effectiveness: * Bronchodilators/beta agonist...Corticosteroids." * "Procedure ... "Bronchodilators...Administer the faster-acting Beta-agonist first... Steroid Inhalers...Administer steroid inhalers 1 minute after the last bronchodilator inhaler for deeper penetration of the steroid in the lungs due to air sacs being dilated."</p> <p>b) Note: Regarding Advair, The Nursing 2013 Drug Handbook, 3rd Edition, 2013, stated on page 618, under Administration, "...After administration, have the patient rinse his mouth without swallowing." And, on page 619, under Patient Teaching, "... Instruct patient to rinse</p>	F 281	<p>IV. Monitoring</p> <p>DNS responsible to oversee the proper method of steroid inhaler administration. DNS or designee will audit two times a week for proper steroid administration for one month then one time a week for two months. DNS or designee will also audit nurses for proper sequencing of bronchodilators and steroid inhalers. Audits will be done two nurses weekly for one month then one nurse a weekly for two months. Findings of these audits will be reported to the Performance Improvement Meeting for trending and further recommendations.</p>	

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F 281	<p>Continued From page 22</p> <p>mouth after inhalation to prevent oral candidiasis..."</p> <p>On 3/12/13 at 9:18 a.m., during the same medication pass observation noted above, LN #2 did not encourage, instruct, or offer to assist Resident #7 to rinse her mouth after the Advair administration. After the Spiriva administration, the LN did assist the resident to rinse her mouth; however, the resident swallowed the rinse water.</p> <p>Immediately afterward, when asked, LN #2 confirmed she had not encouraged, instructed, or offered water for Resident #7 to rinse out her mouth after the Advair administration.</p> <p>In the morning on 3/14/13, the DNS informed the survey team she was aware LN #2 had not had Resident #7 rinse her mouth with water after the administration of Advair.</p> <p>Later that morning, the DNS provided the P&P, Oral Inhalant Administration (Metered Dose Inhalers) which included the following, "Steroid Inhalers...Have resident rinse mouth thoroughly with water immediately following inhalation to wash away steroid residue in the mouth."</p> <p>On 3/14/13 at 4:00 p.m., the Administrator and the Divisional Director of Clinical Operations were also informed of the issues. However, no other information or documentation was received from the facility.</p>	F 281			
F 309 SS=G	<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</p>	F 309			

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F 309	<p>Continued From page 23</p> <p>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 staff interview and medical record review, it was determined the facility did not ensure changes in residents' pain levels were accurately assessed, did not respond timely to complaints of pain, and did not notify the resident's physician of continued complaints of pain after resident falls. Residents also did not receive interventions per physician's orders regarding bowel care. This was true for 3 of 6 residents (Resident #s 1, 2, and 5) sampled for pain and bowel care. The deficient practice caused harm to Resident #2 when there was a delay in treatment after hs falls. Resident #s 1 and 5 had the potential to experience more than minimal harm if they developed constipation. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 9/14/10 with diagnoses including history of motor vehicle accident with skull and nasal fractures, brain abscess, and craniotomy resulting in severe chronic seizure disorder; and intermittent falls and decreased ability to live independently.</p> <p>Resident #2's Quarterly MDS, dated 1/9/13, coded: -BIMS of 5 (severely impaired cognitive skills..) -Extensive assistance of two persons for transfers.</p>	F 309	<p>F-309</p> <p>I. Affected Residents Resident # 2 has a new updated pain assessment. Residents #1 and #5's bowel patterns reviewed related to constipation and interventions.</p> <p>II. Other Residents Audit of other residents related to pain or constipation have been completed to identify further needs.</p> <p>III. Systemic Changes Licensed Nurses re-educated regarding appropriate assessment related to pain after all incidents. Licensed Nurses also re-educated regarding appropriate assessment related to bowel care needs.</p> <p>IV. Monitoring DNS is responsible to oversee those residents with pain after all incidents are accurately assessed. DNS is responsible to oversee that residents' bowel care needs are met. DNS or designee to audit three charts a week for one month then two charts a week for two months. Findings of these audits will be reported to the Performance Improvement Meeting for trending and further recommendations.</p>	04/16/13	

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F 309	<p>Continued From page 24</p> <ul style="list-style-type: none"> -Limited assistance of one person for ambulation. -Extensive assistance of two persons for toilet use. -Continent of bowel and bladder. -Occasional pain level of 5, on a 0 to 10 scale. <p>Resident #2's Change of Condition MDS, dated 2/28/13, coded:</p> <ul style="list-style-type: none"> -BIMS of 4 (severely impaired cognitive skills.) -Extensive assistance of 2 persons for transfers. -Did not ambulate. -Extensive assistance of 2 persons for toilet use. -Frequently incontinent of bowel and bladder. -Almost constant pain level of 8, on a 0 to 10 scale, indicating increased frequency and intensity of pain. <p>a. Beginning 2/3/13, Resident #2's Resident Progress Notes (PNs) documented:</p> <p>On 2/3/13 at 8:45 PM, Condition Change Form, "Resident fell getting up out of bed to use the bathroom. He has an abrasion on his [right] temple and complained about [right] shoulder pain..." [NOTE: There was no documentation of Resident #2's range of motion to his right arm after the fall. There was no documentation of pain interventions implemented, nor the effectiveness of any interventions. There was no documentation of additional assessments completed.]</p> <p>-2/4/13 at 2:30 AM "...Cont to c/o [complain of] [right] shoulder pain. [Right] ice/heat therapy..." [NOTE: 5 hours, 45 minutes had elapsed since the time of the fall. There was no documentation of the effectiveness of the ice and heat implemented for Resident #2's pain. There was</p>	F 309			

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F 309	<p>Continued From page 25</p> <p>no documentation range of motion had been assessed for Resident #2's right arm. There was no documentation Resident #2's physician had been informed of the continued complaints of pain.]</p> <p>-2/4/13 at 4:15 PM, "Res [with] c/o [right] shoulder/arm pain today [related to] previous fall. Tylenol helpful [with] pain." [NOTE: 19 hours, 30 minutes had elapsed since the time of the fall. There was no documentation Resident #2's physician had been notified of Resident #2's continued complaints of pain. There was no documentation of range of motion being assessed on Resident #2's right arm.]</p> <p>-2/5/13 at 2:30 PM, "Res still [with] c/o [right] shoulder pain [related to] previous fall. [No] bruising visible. ROM adequate to [right] arm..." [NOTE: 29, hours 45 minutes had elapsed since Resident #2's fall. There was no documentation Resident #2's physician had been notified of continued complaints of pain.]</p> <p>-2/7/13 at 9:20 AM, Condition Change Form, "Res continues to c/o [right] shoulder pain. c/o [increased] pain [with] movement. Unable to raise arm above shoulder height this AM. [Right] shoulder and upper arm with edema." The form indicated Resident #2's physician was notified at this time. [NOTE: 3 days, 12 hours, 35 minutes had elapsed since Resident #2's fall. There was no documentation of Resident #2's pain levels or assessment of his range of motion documented in the PNs for 2/6/13.]</p> <p>-2/7/13 at 4:10 PM, Condition Change Form, "Phys[ician] phoned res [with] fx [fracture] [right]</p>	F 309			

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F 309	<p>Continued From page 26</p> <p>clavicle. [New order] for pain medication received."</p> <p>Please see F 323 as it pertains to falls and supervision.</p> <p>On 3/12/13 at 4:30 PM, the DNS and DDCO were interviewed regarding Resident #2's fall, and the timing of the assessment of his continued complaints of pain before the fracture was diagnosed. The DNS stated she recalled discussions with the nursing staff regarding this issue. The DNS stated Resident #2 reported pain, but seemed to go about his normal daily routine, including ambulating and smoking, so the nurses did not feel the need to follow up with the physician. The DNS stated, "I recall conversations with the nurses regarding his range of motion, although the assessments don't reflect that. They should have been documenting that." The DNS stated the first changes in Resident #2's range of motion were noted on 2/7/13, so an x-ray was not done until that time.</p> <p>On 3/13/13 at 6:15 PM, the Administrator, DNS, DDCO, and SDC were informed of these findings. The facility offered no further information to resolve the concern.</p> <p>b. Beginning 2/15/13, Resident #2's PNs documented:</p> <p>-2/15/13 at 8:20 PM, Condition Change Form, "Returning to bed from BR [bathroom] [with] walker, found sitting on floor next to bed. [No] injuries noted." [NOTE: There was no documentation of Resident #2's range of motion after the fall. There was no documentation of an</p>	F 309			

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F 309	<p>Continued From page 27</p> <p>assessment of Resident #2's pain after the fall. There was no documentation in Resident #2's PNs until 12:30 PM the following day.]</p> <p>-2/16/13 at 12:30 PM, "Resident has been complaining of severe pain in his [right] groin area since 0730 [7:30 AM] today, calls out in pain frequently. Resident cannot walk, requires two-assist for transfer. Temp 101.3 [degrees]. Resident was found sitting on floor on 2/15 PM shift. Groin [right] is tender to light palpation...Medicated for pain and fever X 2 with Norco, applied ice pack to groin. Informed [physician's name] via telephone about resident's condition at 1230 hrs [12:30 PM]. [Physician's name] stated that he can evaluate the resident on 2/17 Sunday, and directed me to ship resident to the ER [emergency room] if anything worsens..." [NOTE: 5 hours elapsed between the time Resident #2 complained of severe pain, and the time his physician was notified. There was no documentation of Resident #2's range of motion at the time of the onset of his pain complaints.]</p> <p>-2/16/14 at 2:20 PM, "Severe difficulty moving [right] leg, still c/o severe pain '9/10.' Temp 102.1. Shipped to [name of hospital] ER..."</p> <p>-2/16/13 at 9:00 PM, "[Resident #2] returned approx. [7:30 PM] from the [name of hospital] [with] fx of the pubic remus [sic] and ischial body..."</p> <p>Resident #2's MAR for February 2013 documented one Norco 7.5/325 mg tablet given on 2/15/13 and 2/16/13 as follows: -2/15/13 at 5:30 PM (before the fall) for right shoulder pain</p>	F 309			

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F 309	<p>Continued From page 28</p> <p>-2/16/13 at 8:40 AM for severe groin pain, unresolved (This was the first documented dose given after the fall. 12 hours, 10 minutes had elapsed since the time of the fall. 70 minutes had elapsed since the resident had complained of "severe pain.")</p> <p>-2/16/13 at 12:15 PM for pain in the right groin and clavicle, unresolved.</p> <p>On 3/12/13 at 4:30 PM, the DNS and DDCO were asked about the timeframe between Resident #2's fall on 2/15/13, his complaints of pain, and physician notification. The DNS stated Resident #2 was medicated for pain following his fall, but was still complaining of pain the next morning. The DNS could not say for sure how long after the fall Resident #2 was medicated for pain. The DNS stated the nurse on duty the next day, when complaints of severe pain were present, tried ice and pain medication to address Resident #2's pain. The DNS stated when those measures were not effective the nurse notified the physician. The DNS stated the physician planned to see the resident the following day, but to send the resident to the ER if he continued to worsen. The DNS stated Resident #2 continued to experience pain, and his temperature rose, so he was sent to the ER. The DNS was unable to offer information regarding Resident #2's range of motion between the time of the fall and the time Resident #2 complained of pain, or between the time of the fall and the time he was sent to the ER. The DNS stated she was unable to offer further clarification as to why Resident #2's initial complaints of severe pain were not relayed to the physician as soon as they occurred.</p> <p>On 3/13/13 at 10:15 AM, the DNS reported she</p>	F 309			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2013
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - WEISER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 EAST PARK STREET WEISER, ID 83672		
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F 309	<p>Continued From page 29</p> <p>had spoken to the nurse caring for Resident #2 about the timing of the events on 2/16/13. The DNS stated when Resident #2 first complained of pain to the nurse on duty that day, the resident told the nurse it felt like a hernia. Based on that statement from the resident, the nurse felt it would be appropriate to treat with medications and ice to see if those interventions were helpful before notifying the physician. The DNS stated, "It didn't get documented." The DNS was asked if the physician should have been notified of the resident's pain complaints, regardless of the presumed cause. The DNS stated, "yes." The DNS was asked if the physician should be notified of a resident developing a hernia. The DNS stated, "yes."</p> <p>On 3/13/13 at 6:15 PM, the Administrator, DNS, DDCO, and SDC were informed of these findings. The facility offered no further information to resolve the concern.</p> <p>2. Resident #5 was originally admitted the facility on 10/6/10, and most recently readmitted on 12/6/12, with diagnoses which included late effects of right cerebrovascular accident (CVA), left hemiparesis, and insulin dependent diabetes.</p> <p>The resident's most recent quarterly MDS assessment, dated 1/21/13, coded in part:</p> <ul style="list-style-type: none"> * Moderate cognitive impairment with a BIMS score of 11; * Able to understand others and to be understood by others; * Extensive assistance of 2 people for bed mobility and toileting; * Total assistance of 2 people for transfers; and 	F 309			

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F 309	<p>Continued From page 30</p> <p>* Always incontinent of bowel.</p> <p>The resident's annual MDS assessment, dated 8/7/12, coding included constipation was a bowel pattern.</p> <p>On 10/14/10, Resident #5's care plan identified the problem, "Bowel Elimination, Impaired: Constipation." Approaches and their date of incorporation into the care plan included: * "10/14/10 Administer medications as ordered" * "4/12/12 Monitor frequency and consistency of stools Notify MD [physician] if med[ication] ineffective."</p> <p>A recapitulation of the resident's March 2013 Physician's Orders included: * Ten medications (or meds) with constipation listed as a potential adverse reaction (according to the Nursing 2013 Drug Handbook) which included: Fentanyl patch (long acting pain med), routine use of Norco for pain, Gabapentin for neuropathy, Lipid and Atorvastatin for high cholesterol, Plavix for stroke prevention, Lasix for hypertension, ferrous sulfate for anemia, Lexapro for depression, and Risperdal for hallucinations. * Two as needed, or PRN, meds for constipation: Milk of Magnesia (MOM) 30 centimeters at bedtime PRN and Bisacodyl 10 milligram suppository per rectum every day PRN.</p> <p>Review of Flow Sheet Records for January and February 2013 revealed interventions were not implemented when the resident did not have a BM for 3 or more days on: * January - 1/5-1/8 (4 days), 1/12-1/15 (4 days), 1/21-1/23 (3 days), and 1/25-1/31 (7 days); and * February - 2/2-2/5 (4 days), 2/7-2/9 (3 days),</p>	F 309			

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F 309	<p>Continued From page 31 2/11-2/13 (3 days), 2/16-2/19 (4 days), and 2/22-2/25 (4 days).</p> <p>On 3/13/13 at 6:10 p.m., the DNS was asked what, if any, interventions were implemented when Resident #5 did not have a BM for 3 or more days as noted above. The Divisional Director of Clinical Operations was present during the interview. The DNS reviewed the resident's clinical record then stated the aforementioned PRN bowel med interventions were not consistently documented.</p> <p>On 3/14/13 at 4:00 p.m., the Administrator was also informed of the issue. However, no other information or documentation was received from the facility.</p> <p>3. Resident #1 was admitted to the facility on 5/10/11, and readmitted on 11/8/11, with diagnoses which included chronic obstructive pulmonary disease (COPD), depression, anxiety disorder, gastroesophageal reflux disorder (GERD), peripheral neuropathy, and type 2 diabetes. Hospice services started on 5/30/12 for end stage COPD.</p> <p>The resident's most recent quarterly MDS assessment, dated 2/18/13, coded in part: * Moderate cognitive impairment with a BIMS score of 12; * Able to understand others and to be understood by others; * Extensive assistance of 1 person for bed mobility, transfers, and toileting; and * No bowel incontinence.</p> <p>A recapitulation of the resident's March 2013 Physician's Orders included:</p>	F 309			

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F 309	<p>Continued From page 32</p> <p>* Seven medications (or meds) with constipation list as a potential adverse reaction (according to the Nursing 2013 Drug Handbook) which included: routine and PRN (as needed) Norco for pain, PRN liquid morphine sulfate (fast acting pain med), diltiazem for hypertension, calcium with vitamin D as a supplement, risperidone for schizo-affective disorder, PRN Haldol for agitation, and routine and PRN clonazepam for restlessness/anxiety/agitation.</p> <p>* Milk of Magnesia (MOM) 30 centimeters at bedtime if no BM.</p> <p>Review of Flow Sheet Records for January and February 2013 revealed interventions were not implemented when the resident did not have a BM for 4 days on 1/12-1/15 and 2/16-2/19.</p> <p>On 3/13/13 at 2:25 p.m., the DNS was asked what, if any, interventions were implemented when Resident #1 did not have a BM for days as noted above. The Divisional Director of Clinical Operations was present during the interview. The DNS indicated she would review the resident's clinical record and get back with the surveyor.</p> <p>At 5:50 p.m., the DNS stated, "I have no further information." The DNS confirmed there were no interventions documented when Resident #1 did not have a BM as noted above. The SDC was present during the interview.</p> <p>On 3/14/13 at 4:00 p.m., the Administrator was also informed of the issue. However, no other information or documentation was received from the facility.</p>	F 309			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315			

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F 315	Continued From page 33 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on closed record review, staff interview, Resident Infection Reports, and policy and procedure (P&P) review, it was determined the facility failed to ensure a resident who was admitted to the facility with an indwelling catheter received the appropriate care and services to prevent infections. This was true for 1 of 2 residents (Resident #10) reviewed for indwelling catheters. Resident #10's Admission Orders and Interim Plan of Care did not include the Foley catheter. And, a physician order for the indwelling catheter and a care plan update, both dated one week after admission, did not address the care of the catheter, tubing, or drainage bag. Furthermore, there was no documented evidence care of the catheter, tubing or drainage bag was provided; and, nine days after admission, the resident developed a symptomatic urinary tract infection (UTI). Findings include: Resident #10 was admitted to the facility on 2/1/13 with diagnoses which included chronic pain, muscle disuse atrophy, candidal	F 315	F-315 I. Affected Residents Resident # 10 was discharged from the facility prior to the start of the survey. Resident # 10 was receiving appropriate care and services prior to discharge. II. Other Residents Facility identified one other resident with indwelling catheter. This resident has been reviewed to validate appropriate care and services related to catheter care are in place. III. Systemic Changes Nursing Staff re-educated related to proper documentation of catheter care to prevent infections. IV. Monitoring DNS responsible to oversee that appropriate care and service related to catheter care to prevent infections is provided. DNS or designee will review residents admitted with catheter for appropriate care and services. In addition, audits of the documentation of care will be done weekly for one month then twice a month for two months. Findings of these audits will be reported to the Performance Improvement Meeting for trending and further recommendations.	04/16/13	

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F 315	<p>Continued From page 34</p> <p>vulvovaginitis, neurogenic bladder, and personal history of UTI. In addition, an Emergency Room Record, dated 2/1/13, noted, in part, "...chronic Foley catheter secondary to bladder surgery one year ago. [and] Foley catheter was changed [2/1/13]." On 2/21/13, the resident was discharged to an Assisted Living Facility in another town.</p> <p>Resident #10's admission MDS assessment, dated 2/8/13, coded, in part:</p> <ul style="list-style-type: none"> * Intact cognition with a BIMS score of 13; * Adequate hearing and clear speech; * Able to be understood and to understand others; * Extensive 2 person assistance for bed mobility and 1 person for dressing/personal hygiene; * Total 2 person assistance for transfers/toileting; and * Indwelling catheter. <p>The analysis of findings in the resident's Urinary Incontinence and Indwelling Catheter CAA, dated 2/11/13, included the following documentation, "...catheter for neurogenic bladder. Res[ident] reported she started using the indwelling catheter in April or May 2011. Usually continent of bowels though one episode of bowel incontinence noted since admit in record. Proceed [with] CP [care plan]."</p> <p>Care plans found in Resident #10's closed record documented, in part:</p> <ul style="list-style-type: none"> * Interim Plan of Care, dated 2/1/13 - Included a Bladder/Bowel Status section; however, the space to mark Indwelling Catheter was blank. * A Self-Care Deficit Toileting care plan, also dated 2/1/13 - "Self-Care Deficit Toileting R/T 	F 315			

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F 315	<p>Continued From page 35</p> <p>[related to] pain [and] impaired mobility." Two pre-typed approaches were circled (indicated they were to be implemented). The 2 approaches were, "Toilet with AM & PM [morning and evening] care, before meals and rest periods and PRN [as needed]. Pericare after each incontinent episode." and "Bedside commode as needed." Note: Indwelling Foley catheter was not included in this part of the care plan.</p> <p>* An ADL's care plan, also dated 2/1/13 - "Self Care Deficit R/T Weakness [and] pain." Pre-typed circled approaches included, "...shower/bath 2 times a week..." and "Provide AM and PM cares per facility protocol." In addition, an undated handwritten approach was, "Requests only 1 bath a week but is offered 2."</p> <p>Note: Again use of the indwelling catheter was not included in this part of the care plan.</p> <p>* A Care Plan Update, dated 2/7/13 - "Toileting R/T foley [sic] d/t [due to] kidney stones/retention." The only approach listed was, "Foley to BSU [bedside unit, also known as a drainage bag] as ordered."</p> <p>Note: This update to the care plan did not include care of the catheter, tubing, or BSU.</p> <p>* An Initial Care Plan Report, dated 2/11/13 - Identified the problem, "Urinary Elimination, Altered Pattern." Approaches were, "Bladder Assessment per facility policy, praise successes/efforts, [and] monitor for s/sx [signs and symptoms] UTI. Report to MD [physician] if 2 or 3 s/sx noted."</p> <p>Note: This care plan did not note the presence of the Foley catheter or address the care of the catheter, tubing, or BSU.</p> <p>The resident's Admission Orders Record, dated 2/1/13, included the following orders:</p>	F 315			

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F 315	<p>Continued From page 36</p> <ul style="list-style-type: none"> * SMZ/TMP double strength, an antibiotic for UTI prophylaxis; * Anusol for hemorrhoids; * Calmoseptine ointment vaginally; and * Ciciopirox cream to vaginal area at bedtime for fungal infection. <p>Note: The Admission Orders did not include the indwelling Foley catheter.</p> <p>A Physician Telephone Order (PTO), dated 2/7/13, documented, "Foley to BSU R/T kidney stones/retention [change] Q mo & PRN [Foley catheter to bedside unit related to kidney stones and retention, change every month and as needed.]"</p> <p>Review of the resident's MAR, TAR, and Flow Sheet Records for February 2013 and Resident Progress Notes (RPN), dated 2/1/13 at 7:50 p.m. through 2/21/13 at 10:50 a.m., revealed there was no documentation the indwelling Foley catheter was secured, catheter care was provided, or the BSU was maintained below bladder level.</p> <p>Resident Progress Notes (RPN), dated 2/1/13 at 7:50 p.m. through 2/21/13 at 10:50 a.m., revealed there was no documentation the indwelling Foley catheter was secured, catheter care was provided, or the BSU was maintained below bladder level. They also documented:</p> <ul style="list-style-type: none"> * Complaints about vaginal and/or hemorrhoid/rectal burning and/or irritation on 2/2 at 3:00 a.m., 2/2 on the AM shift, 2/3 at 3:38 a.m., 2/3 at 6:00 p.m., and 2/7 untimed. * 2/9 at 3:40 p.m. - "...amber foul-smelling urine, disoriented to place and situation, and temperature 100.2 [degrees Fahrenheit]." 	F 315			

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F 315	<p>Continued From page 37</p> <p>Note: A Urinalysis, dated 2/9/13 at 4:35 p.m., was positive for UTI and documented that a urine culture was ordered.</p> <p>Note: A PTO, dated 2/9/13 at 6:45 p.m., included an order for a 10 day course of Ciprofloxacin (an antibiotic) for UTI.</p> <p>* 2/10 at 2:55 p.m. - through 2/11 at 3:30 a.m. - Noted increased confusion, lethargy, and nonsensical conversation.</p> <p>* 2/11 at 2:50 p.m. - "MD in today...Push fluids..."</p> <p>* 2/11/13 at 6:10 p.m. - "... Res [with increased] awareness...drinking lots of water... Urine draining yellow [with] sediment..."</p> <p>* 2/13 at 6:00 p.m. - "...[increased] awareness / responsiveness today..."</p> <p>* 2/19 untimed - "...Feeling so much better since UTI resolved..."</p> <p>On 3/14/13 at 10:00 a.m., the Infection Preventionist (IP) was interviewed. The IP provided a Resident Infection Report, dated 2/6, which documented a community acquired vaginal fungal skin infection was present on admission and resolved on 2/2/13; and, that ciclopirox topical cream was ongoing. The IP also provided a Resident Infection Report, dated 2/11/13, which documented a positive UTI with symptoms observed 2/9/13. The IP confirmed the 2/9/13 UTI was facility acquired.</p> <p>On 3/14/13 at 1:30 p.m., the DNS was interviewed. The Divisional Director of Clinical Operations was present. When asked about physician orders and the care plan for Resident #10's indwelling catheter, the DNS stated the resident was admitted in the evening on 2/1/13 with the Foley catheter present on admission. The DNS also stated, "There were no orders for</p>	F 315			

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F 315	<p>Continued From page 38</p> <p>the catheter until 2/7/13 when I realized the Foley was not in the admit orders." Regarding the care plan, the DNS stated the 2/7/13 Care Plan Update was, "The start of the catheter care plan." And, after review of the Interim Care Plan for Urinary Elimination, the DNS stated, "It's not filled out." The DNS confirmed there were no other care plans regarding the indwelling catheter. Also, when asked for documentation regarding catheter management, including catheter care, how the BSU was positioned, the DNS confirmed there was no such documentation. P&P on indwelling catheters and catheter care were requested at that time.</p> <p>A few minutes later, the DNS provided an Indwelling Catheters P&P and an Indwelling Urinary Catheter Care P&P, both dated 8/31/12. These P&P included the following documentation: * Indwelling Catheters - "POLICY ...Care and treatment are provided to help...reduce catheter associated complications such as a urinary tract infection. RATIONALE: ...If an indwelling catheter is medically justified and inserted, interventions should be in place to reduce the likelihood of an infection. COMPONENTS: ... 9. Infection control is followed in the care of indwelling catheters. Guidelines to prevent Catheter Associated Infections (CAUTI) include but may not be limited to: ... b. The smallest gauge catheter possible is used. ... f. Catheter tubing is secured using anchoring device to prevent movement and urethral traction. g. Sterile, closed drainage system is maintained. h. Good hygiene is maintained at the catheter-urethral interface: cleaned daily with soap and water. i. Unobstructed urine flow and drainage bag positioning below the level of the bladder is</p>	F 315			

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F 315	Continued From page 39 maintained. 10. The care plan reflects: ...Intervention to reduce or prevent urinary tract infections..." * Indwelling Urinary Catheter Care - "Procedure... 9. Wash perineum beginning at the junction of the catheter tubing and meatus working outward to the surrounding perineal structures with soap and warm water or a no rinse cleansing solution and cleaning from front to back... 10. Cleanse area well and remove all debris from catheter at insertion site... 11. Rinse well with warm water, unless [using] a no rinse cleansing solution and pat dry gently with a clean towel." The facility did not ensure physician orders and a care plan regarding indwelling catheters were in place when the Resident #10 was admitted to the facility with an indwelling catheter in place. And, nine days after admission to the facility, the resident, who had a history of UTI, developed a symptomatic UTI. Furthermore, the facility did not follow their own P&P regarding indwelling catheters and catheter care as there was no documented evidence that any interventions were implemented in an effort to prevent UTI. On 3/14/13 at 4:00 p.m., the Administrator was also informed of the issue. However, no other information or documentation was received from the facility.	F 315			
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F-323 I. Affected Residents Resident # 2 has been assessed and care plan reviewed and updated related to fall prevention. Resident #4 dining plan has been reviewed and care plan updated related to dining needs.	04/16/13	

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2013
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - WEISER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 EAST PARK STREET WEISER, ID 83672		
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F 323	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility did not ensure each resident received adequate supervision to prevent falls, and did not ensure supervision as required at meal times. This was true for 2 of 9 residents (#s 2 and 4) sampled for supervision. Resident #2 was harmed when he experienced decreased ability to complete ADLs, decreased ability to ambulate, increased incontinence and increased pain from fractures sustained as a result of his falls on 2/3/13 and 2/15/13. Resident #4 had the potential for more than minimal harm when he was placed in a room without direct supervision or physical assistance at meals. Findings included: 1. Resident #2 was admitted to the facility on 9/14/10 with diagnoses including history of motor vehicle accident with skull and nasal fractures, brain abscess, and craniotomy resulting in severe chronic seizure disorder; intermittent falls and decreased ability to live independently; history of Hepatitis C; and history of migraines. Resident #2's Quarterly MDS, dated 1/9/13, coded: -BIMS of 5 (severely impaired cognitive skills.) -Extensive assistance of two persons for transfers. -Limited assistance of one person for ambulation. -Extensive assistance of two persons for toilet use.	F 323	II. Other Residents Other residents who have sustained falls have been assessed and care plans updated as needed. Audit of other residents eating meals outside of the dining room have been assessed and care plans updated as needed. III. Systemic Changes Licensed Nurses and IDT members re-educated regarding proper fall prevention measures for residents who have sustained a fall including previous fall history, MDS data, and care plan review. Nursing Staff re-educated regarding appropriate supervision for residents at meal times. IV. Monitoring DNS responsible to oversee residents to validate those residents have appropriate interventions for fall prevention including review of previous fall history, MDS, data, and care plan review. DNS responsible to oversee residents to validate those residents have adequate supervision during meal times. DNS or designee will audit fall prevention by auditing three charts a week. These audits will be done weekly for two months then 2 charts weekly for one month. DNS or designee will audit four residents at meal times. These audits will be done two times a week for three months. Findings of these audits will be reported to the Performance Improvement Meeting for trending and further recommendations.		

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F 323	<p>Continued From page 41</p> <ul style="list-style-type: none"> -Continent of bowel and bladder. -Occasional pain level of 5, on a 0 to 10 scale. <p>Resident #2's Change of Condition MDS, dated 2/28/13 , coded:</p> <ul style="list-style-type: none"> -BIMS of 4 (severely impaired cognitive skills.) -Extensive assistance of 2 persons for transfers. -Did not ambulate. -Extensive assistance of 2 persons for toilet use. -Frequently incontinent of bowel and bladder. -Almost constant pain level of 8, on a 0 to 10 scale, indicating increased frequency and intensity of pain. <p>The CAA summaries associated with the 2/28/13Change of Condition MDS documented:</p> <ul style="list-style-type: none"> -Urinary Incontinence and Indwelling Catheter, "Res [with] decline in continence [related to] decline in ADL's [related to] fractures [and] non-wt. bearing status... Staff using bedpan and bedside commode for res elimination needs..." -Falls, "Res [with] 3 falls since last assessment - 2 [with] major injury. Fall 2/3/13 [with] shoulder pain [and] lateral clavicle fx [and] [left] 3rd rib fx [fracture] resulting. Fall 2/15/13 [with] resulting fx of anterior acetabulum. Mobility impaired [related to] fx [and] pain. Hx of seizure activity though falls [with] fx appear to be unrelated to seizures..." -Pain, "Res [with] pain [related to] pelvic fx. Norco QID [four times daily] ordered 2/8/13..." <p>Resident #2's care plan for the problem area "Risk for Falls", initiated 9/20/10, documented:</p> <ul style="list-style-type: none"> -"Assess cause, pattern of previous falls [and] act on resolvable factors." Date initiated 9/23/10. -"BSC or bedpan for bowel urgency." Date initiated 2/28/13. -"Vertical bar to outside of bathroom for safe 	F 323			

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F 323	<p>Continued From page 42</p> <p>transfers." Date initiated 10/4/10. -"Bed against wall to provide resident with spacial perimeter and security." Date initiated 12/15/10. -"Non-skid strips by bed." Date initiated 8/9/11. -"If staff has knowledge of resident using bathroom, place walker so resident can push rather than pull walker when using bathroom." Date initiated 12/19/11.</p> <p>On 1/24/13 at 6:45 PM, a Condition Change Form in Resident #2's Resident Progress Notes (PNs) documented, "Res found sitting on floor [with] walker in front of him. Amb[ulating] to BR [bathroom]."</p> <p>On 1/24/13 at 6:45 PM, a facility "Post-Event Investigation/Interviews" form documented: -Event description as, "Res[ident] sitting on floor next to wall. Res slid down wall to sit on floor with walker in front of him." -The "What happened?" area of the form documented, "Res transferring to BR, became weak." -The "Why did it happen?" area of the form documented, "Res is unsteady with ambulation at times." -The "Fall Description" area of the form documented Resident #2 as "Indep[endent]" with toileting. -The "PI Recommendations" area of the form documented, "No [change] to plan of care [POC]." -The "Condition Change Form" area of the form documented, "Res had not used BR prior to fall...nothing out of the ordinary to allow staff to predict fall. [No change] POC."</p> <p>On 2/3/13 at 8:45 PM, a Condition Change Form in Resident #2's PNs documented, "Resident fell</p>	F 323			

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F 323	<p>Continued From page 43</p> <p>getting up out of bed to use the bathroom. He has an abrasion on his [right] temple and complained about [right] shoulder pain..."</p> <p>On 2/3/13 at 8:45 PM, a facility "Post-Even Investigation/Interviews" form documented: -Event Description as, "Heard a crashing noise went to look for the cause and found resident on the floor on his right side with his right arm above his head and his head resting on his right arm. He stated he needed to go to the bathroom..." -The "What happened?" area of the form documented, "I think [Resident #2] was getting up to go to the bathroom and tried to use his table to get up and his table moved and he fell...has a[n] abrasion on the right temple and he states his right shoulder hurts." -The "Why did it happen?" area of the form documented, "He became off balanced trying to use the bedside table to get up." -The "Fall Description" area of the form documented the time Resident #2 was last toileted as, "Self." -The "PI Recommendations" area of the form documented, "[Changed] that stationary over the bed table in place." -The "Condition Change Form" area of the form documented, "Upon investigation res got OOB [out of bed] [independently] per usual routine [and] fell hitting his [right] temple [and] shoulder on over bed table. Res needing to use the bathroom..."</p> <p>On 2/7/13 at 9:20 AM a facility Condition Change Form in Resident #2's PNs documented, "Phys[ician] phoned res [with] fx rt clavicle. [new order] for pain medication received." [NOTE: Please see F 309 as it pertains to the</p>	F 323			

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F 323	<p>Continued From page 44 timeframe between the fall and diagnosis of the fracture.]</p> <p>On 2/15/13 at 8:20 PM, A Condition Change Form in Resident #2's PNs documented, "Res returning to bed from BR [with] walker, found sitting on floor next to bed. [No] injuries noted."</p> <p>On 2/15/13 at 8:20 PM, a "Post-Event Investigation/Interviews" form documented: -Event Description as, "Heard res yell 'Help.' Res sitting on floor [with] back to bed..." -The "What happened?" area of the form documented, "Res returning from BR [with] walker. Backed up to bed to sit down, sat on floor." -The "Why did it happen?" area of the form documented, "Res unsteady." -The "Fall Description, Recreate the life of the resident prior to the fall" area of the form documented, "[Up] to BR." -The "PI Recommendations" area of the form documented, "Request PT eval[ulate] and [treat]." -The "Condition Change Form" area of the form documented, "Res [with] fall 2/15/13 at [8:20 PM] when returning to bed from bathroom [with] walker [and] backed up to bed to sit down [and] sat on floor...Fx [fracture] of pelvic remus [and] ischial body noted..." [NOTE: Please see F 309 as it pertains to the timeframe between the fall, diagnosis of the fracture, and pain.]</p> <p>On 2/16/13 at 2:30 PM, Resident #2 was seen in the emergency room at [hospital name.] Resident #2's Emergency Room Record documented, in part, "...x-rays of the right hip and...pelvis...showed pelvic fracture along the</p>	F 323			

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F 323	<p>Continued From page 45</p> <p>medial aspect of the right acetabulum...patient is nonambulatory at this time due to pain...he can remain at bed rest at that facility [the SNF] and have orthopedic consult regarding the medical acetabular fracture..."</p> <p>On 2/20/13, a Physical Therapy Evaluation form in Resident #2's record documented, in part, "Pt fell sustaining [right] clavicle [fracture] 2/7/13. Then he fell again [and] fractured [right] pelvis. He is non-wt [weight] bearing on [right] LE [lower extremity.]"</p> <p>On 3/7/13 at 7:00 PM, a Condition Change Form in Resident #2's PNs documented, "Res [up] self transferring to BSC [bedside commode] next to bed. Found on knees in front of BSC [with] apx [approximately] 2 inch laceration to rt [right] eyebrow..."</p> <p>On 3/7/13 at 7:00 PM, a "Post-Event Investigation/Interviews" form documented: -Event Description as "Heard yell help me. Res on knees next to BSC with blood drops on the floor." -The "What happened?" area of the form documented, "Had to go to the bathroom." -The "Why did it happen?" area of the form documented, "I don't know." -The "PI Recommendations" area of the form documented, "[15 minute checks.] Floor mat alarm." -The "Condition Change Form" area of the form documented, "Res found on floor on knees next to BSC [with] pants/depends down per staff report. Res had self-transferred to [and] used commode [and] fell when transferring off commode. Laceration to [right] eyebrow..."</p>	F 323			

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F 323	Continued From page 46 On 3/12/13 at 4:30 PM, the DNS and the DDCO were asked about Resident #2's falls. The DNS stated the facility's interdisciplinary team (IDT) usually met to discuss resident events the next business day after they occurred, then met to review how successful the facility's new interventions were about a week later. Regarding Resident #2's falls, the DNS stated the following: -For the fall on 1/24/13, Resident #2 had been seen lying in bed 15 minutes prior to the fall, and had likely gotten up to take himself to the bathroom, became weak, and fell to the floor. The DNS stated staff would not have been present to assist, as Resident #2 was independent with this activity. The DNS was asked about Resident #2's MDS from 1/9/13 which coded Resident #2 as needing extensive assistance of two persons for toileting, and limited assistance of one person for ambulation. The DNS stated that information was surprising to her, as she knew Resident #2 to be independent with ambulation and toileting. The DNS stated the facility's IDT had reviewed the event, and determined the care plan interventions in place at the time were appropriate, and no changes were warranted. The DNS was asked about what interventions were in place on Resident #2's care plan at the time of that fall. The DNS stated that she did not recall that information, and would have to look it up. However, this information was not provided. -For Resident #2's 2/3/13 fall, the DNS stated the IDT focused on Resident #2's bedside table as his room floor had been waxed shortly before the fall, and a different bedside table was placed in his room after it was waxed. The DNS re-iterated Resident #2 was noted to be independent with toileting and ambulation, and she would have to	F 323			

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F 323	<p>Continued From page 47</p> <p>follow up on the information in Resident #2's MDS. The DNS was asked if Resident #2's toileting pattern or care plan was looked at as a result of this fall. The DNS stated the IDT had focused primarily on the environment, and had not discussed toileting as a possible contributing factor to Resident #2's falls.</p> <p>-For Resident #2's 2/15/13 fall, the DNS stated Resident #2 had just gone to the bathroom, backed up to sit on his bed, and fell to the floor. She stated no staff were present, as Resident #2 was noted to be independent with toileting and ambulation. The DNS stated even though all of these falls had been in the evening hours and related to toileting needs, Resident #2's voiding patterns and care plan had not been re-evaluated.</p> <p>-The DNS stated Resident #2 did have an increase in his pain level as a result of the fractures he sustained in the falls, but his pain level seemed to be returning to baseline as his fractures healed. The DNS stated while Resident #2 technically required more assistance for ADLs after his falls, "He was non-compliant, so his restrictions didn't really slow him down." The DNS stated Resident #2 did show increased incontinence due to the use of lactulose for his Hepatitis C, which caused him to have a sense of urgency with his bowels. She stated he had used that medication for a long time, and urgency with his bowels was not a new development for Resident #2.</p> <p>On 3/13/13 at 10:15 AM, the DNS and DDCO were asked about Resident #2's fall on 3/7/13 The DNS stated at that time, Resident #2 was to have assistance with toileting, as he was made non-weight bearing as a result of his fall on</p>	F 323			

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F 323	<p>Continued From page 48</p> <p>2/15/13. The DNS stated Resident #2 had stood after using the commode, and attempted to return to bed before pulling his pants up. The DNS stated the resident had put himself on the commode, and no staff were present when he fell. The DNS stated the facility had not evaluated Resident #2's voiding patterns or updated his care plan as a result of his fall. The DNS did state the facility placed a floor mat alarm at Resident #2's bedside as a result of this fall.</p> <p>On 3/13/13 at 2:30 PM, the MDS nurse was interviewed about Resident #2's 1/9/13 MDS and functional status. The MDS nurse stated she had based the MDS information on the instructions in the RAI. The MDS nurse stated, "The RAI states if a resident needs physical assistance 3 or more times during the look-back period, then it must be coded on the MDS. [Resident #2] was different in the evenings. He needed more physical help." The MDS nurse stated the information on the 1/9/13 MDS was accurate.</p> <p>On 3/13/13 at 6:15 PM, the Administrator, DNS, DDCO, and SDC were informed of the surveyors findings. The DNS stated the facility had started tracking Resident #2's voiding patterns the previous evening, and would be reviewing the information to update Resident #2's care plan once the data collection was complete. However, this information did not resolve the concern regarding the facility's evaluation of Resident #2's voiding patterns and need for assistance prior to the falls and fractures, nor the concern with the implementation of supervision and assistance as a result of those evaluations.</p> <p>Resident #2 was harmed when he fell in the</p>	F 323			

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F 323	<p>Continued From page 49</p> <p>facility on four occasions (1/24/13, 2/3/13, 2/15/13, and 3/7/13), and sustained fractures on two of those occasions.</p> <p>2. Resident #4 was admitted to the facility on 5/1/12 with diagnoses including Lewy body dementia with psychosis and aspiration pneumonia.</p> <p>Resident #4's Annual MDS assessment, dated 2/18/13, coded: -Unable to complete the BIMS, assessed by staff with moderately impaired decision making skills. -Extensive assistance of two persons for transfers. -Limited physical assistance from one person to eat meals. -Has had two or more falls without injury since the last assessment.</p> <p>Resident #2's care plan documented: -5/2/12, Problem description, "Swallowing, impaired, R/T dysphagia." -5/2/12, Approach, "Instruct family about feeding techniques." -1/16/13, Approach, "Maintain in optimum position for eating [and] digesting food."</p> <p>[NOTE: There were no care plan approaches describing what optimum positioning would entail. There were no care plan approaches for staff to supervise or assist Resident #2 during meals. There were no care plan approaches for Resident #2 to dine in a room by himself.]</p> <p>On 3/12/13 at 8:30 AM, Resident #4 was observed to be eating his breakfast meal in the Willow Room. He was the only person in that</p>	F 323			

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F 323	<p>Continued From page 50</p> <p>room. The DNS entered the room at 8:30 AM, approached Resident #2, asked if he was close enough to the table to eat, then left the room. Resident #2 was then in the room alone, with no other residents or staff, until 8:37 AM. At 8:37 AM, the DNS returned to the Willow Room, cued Resident #4 to eat his roll and drink his juice, then adjusted his lap tray. At 8:40 AM, the DNS left the Willow Room and Resident #4 was again unattended. At 8:45 AM, Resident #4 was approached by LPN #2, and cued to eat his roll. The DNS briefly returned to the room, but both LPN#2 and the DNS left the room after approximately one minute. Resident #4 was unsupervised and unassisted for the remainder of the breakfast meal.</p> <p>[NOTE: Resident #4 was not offered physical assistance to eat his meal, as identified in the MDS. LPN#2 was periodically in the hallway outside the Willow Room at the med cart, pouring medications, but once the medications were poured, LPN #2 left the hallway. Please see F 221 as it pertains to Resident #4's positioning during the meal.]</p> <p>On 3/12/13 at 3:30 PM, during a family interview, [Resident #4's family member] stated, 'My only concern, and this was at his previous facility, he [Resident #4] was not supervised enough at meals, and he developed aspiration pneumonia and was sent to the hospital.'</p> <p>On 3/13/13 at 10:25 AM, the DNS was interviewed about supervision and assistance for Resident #4 at meals. The DNS reported there had been a speech therapy evaluation and Resident #4 was determined not to be at risk for</p>	F 323			

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

PRINTED: 04/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2013
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - WEISER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 EAST PARK STREET WEISER, ID 83672		
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F 323	Continued From page 51 aspiration pneumonia. On 3/13/13 at 6:15 PM, the DNS provided documentation of a speech therapy discharge summary dated 11/28/12. The discharge summary documented, in part, "Swallow: now self-feeds; minimal s/sx [signs and symptoms] of aspiration...can attend [approximately] 10-15 minutes 40-50 [percent] of the time [with] max cues...Nursing staff and family educated to provide maximal context (tactile, visual, environmental) to support meaningful communication and [increased] attention; family trained to feed pt [patient] safely and recognize s/sx of aspiration." However, this information did not resolve the concern for supervision and assistance for Resident #4 at meals.	F 323			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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. 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	F 329	F-329 I. Affected Residents Resident #4's monitoring use of hypnotic medication has been adjusted to reflect Licensed Nurses schedule. II. Other Residents Other residents with hypnotic medication have been reviewed for appropriate monitoring.	04/16/13	

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F 329	<p>Continued From page 52</p> <p>behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility did not ensure ongoing monitoring for the use of a hypnotic medication. This was true for 1 of 6 (Resident #4) residents sampled for medication use. This deficient practice had the potential to cause more than minimal harm when the effectiveness of Resident #4's hypnotic medication could not be accurately assessed. Findings included:</p> <p>Resident #4 was admitted to the facility on 5/1/12 with a diagnosis of Lewy body dementia.</p> <p>Resident #4's 2/18/13 Annual MDS assessment coded: -Unable to complete BIMS, assessed by staff with moderately impaired decision making skills. -Unable to complete mood interview. -Mood assessed by staff as: *Feels or appears down, depressed, or hopeless more than half of the days in the past two weeks. *Feels tired or have little energy nearly every day in the past two weeks. *Has trouble concentrating nearly every day in the past 2 weeks, *Moves slowly or is fidgety more than half of the days in the past two weeks. *Has had no difficulty falling or staying asleep, no</p>	F 329	<p>III. Systemic Changes Licensed Nurses re-educated regarding appropriate monitoring for residents using hypnotic medication.</p> <p>IV. Monitoring DNS responsible to oversee residents who have hypnotic medication have proper monitoring of the use of these medications. DNS or designee will audit three charts for appropriate monitoring of hypnotic medication usage. Audits will be done weekly for one month then two charts weekly for two months. Findings of these audits will be reported to the Performance Improvement Meeting for trending and further recommendations</p>		

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F 329	<p>Continued From page 53</p> <p>difficulty sleeping too much in the past two weeks.</p> <p>Resident #4's Physician's Orders (recaps) for March 2013, with an order date of 1/15/13, included Ambien 5 mg every day at bedtime.</p> <p>Resident #4's MAR's for January, February, and March 2013, with an order date of 6/6/12, included, "Hypnotic/sedative document hours of sleep." There was a space to document hours of sleep for day, evening, and night shift.</p> <p>Resident #4's MARs did not have hours of sleep documented for at least one shift on the following dates:: January: 1/11/13, 1/13/13 1/14/13, 1/17/13, 1/19/13, 1/20/13, 1/28/13, 1/30/13. February: 2/1/13, 2/4/13, 2/5/13, 2/7/13, 2/10/13 thru 2/12/13, and 2/14/13 thru 2/28/13. March: 3/1/13 thru 3/5/13, 3/7/13, 3/8/13, 3/10/13 thru 3/12/13.</p> <p>On 3/13/13 at 10:25 AM, the DNS and DDCO were asked about the sleep monitor for Resident #4. The DNS stated the sleep monitor should be filled out at the end of each shift, with a value of 0-8 indicating how many hours the resident slept. The DNS reviewed the sleep monitors for Resident #4 and stated, " I know where you're going with this. They should be filled out with no holes."</p> <p>On 3/13/13 at 6:15 PM the Administrator, DNS, DDCO, and SDC were informed of the surveyor's findings. The facility offered no further information to resolve the concern.</p>	F 329			

Bureau of Facility Standards

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual recertification and complaint investigation survey of your facility. The surveyors conducting the survey were: Nina Sanderson, BSW LSW - Team Coordinator Linda Kelly, RN	C 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
C 123	02.100,03,c,vii Free from Abuse or Restraints vii. Is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient/resident from injury to himself or to others; This Rule is not met as evidenced by: Please see F 221 as it pertains to physical restraints.	C 123	See POC for F221 RECEIVED APR 24 2013 FACILITY STANDARDS	04/16/13
C 125	02.100,03,c,ix Treated with Respect/Dignity ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F164 as it related to maintaining	C 125	See POC for F164	04/16/13

Bureau of Facility Standards

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

TITLE
Executive Director

(X6) DATE
4/24/13

Bureau of Facility Standards

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C 125	Continued From page 1 residents' dignity during cares	C 125		
C 173	02.100,12,d Immediate Notification of Physician of Injury d. The physician shall be immediately notified regarding any patient/resident injury or accident when there are significant changes requiring intervention or assessment. This Rule is not met as evidenced by: Please see F 157 as it pertains to physician notification.	C 173	See POC for F157	04/16/13
C 422	02.120,05,p,vii Capacity Requirments for Toilets/Bath Areas 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. This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility did not have one bathing facility for every 12 licensed beds. The facility was licensed for 76 beds, which required 7 bathing facilities. The facility had only 3 permanent bathing facilities, plus 3 temporary bathing facilities stored in the basement. The Administrator was informed of these findings on 3/14/13 at 4:00 PM. The facility offered no further information to resolve this concern.	C 422	C-422 Affected Residents The facility has adequate shower and bathing units to meet the needs of our current resident census. Other Residents If our census increases to a level higher then our current need we have portable shower units on site that can be used to meet the needs. Systemic Changes All portable shower units will be moved from our basement storage to a shed just outside the back door and will be accessible for staff to use as needs arise.	04/16/13

Bureau of Facility Standards

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C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of Infection Control Committee (ICC) meeting attendance records, it was determined the facility failed to ensure ICC members regularly attended Infection Control Meetings. Specifically, the Pharmacist did not attend any of the meetings. In addition, the DNS, Infection Preventionist (IP), physician, and a housekeeping representative did not attend the meetings on a regular basis. The failure of key committee members to be involved in Infection Control, as evidenced by their attendance at meetings, created the potential for a negative affect all residents, staff and visitors in the facility. Findings included:</p> <p>On 3/14/13 at from 10:00 - 10:45 a.m., the IP was interviewed regarding the facility's Infection Control program. When asked about the ICC meetings, the IP stated the meetings were conducted weekly and during monthly Performance Improvement (PI) meetings. She stated the Medical Director, pharmacy consultant, all department heads, the Administrator, and 3 or 4 other staff attended the monthly meetings. The minutes and attendance records for the last 4 monthly ICC meetings were requested. The IP agreed and said she would inform the Administrator of the request.</p> <p>On 3/14/13 at 11:05 a.m., the IP provided the requested information, which included ICC meeting attendance records for 11/8/12,</p>	C 664	<p>Monitoring Executive Director is responsible to oversee that the facility has adequate shower units to meet the needs of the residents who live in the facility. A waiver will be requested to satisfy the C 422 rule as we do not have enough shower units to meet our current licensed beds; however we do have adequate shower units to meet our current census. Furthermore if our census does increase we have portable units that staff can access to meet any increased needs if the census goes up. Any issues or concerns that come up will be reported at our Performance Improvement Meeting for trending and further recommendations</p> <p>C-664 Affected Residents The facility does have a infection control committee that is active and works to prevent infections in the facility.</p> <p>Systemic Changes The infection control committee will meet at least quarterly as part of our facility's Performance Improvement meeting. All required members will be required to attend meeting at least quarterly. If the pharmacist is unable to meet in person he will attend via phone conference.</p>	04/16/13

Bureau of Facility Standards

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C 664	Continued From page 3 12/13/12, 1/10/13, and 2/14/13. Then, the IP stated, "The pharmacist doesn't attend infection control meetings during the monthly PI meetings or the weekly meetings. But, he does review the material monthly." At 11:10 a.m., the DNS joined the above conversation. The DNS stated, "We are working on a plan for the pharmacist to attend quarterly PI meetings related to infection control." Review of the aforementioned ICC meeting attendance records revealed other committee members did not attend ICC meetings as follows: * Physician - 11/8/12; * IP - 12/13/12; * Housekeeping representative - 1/10/13; * DNS - 2/14/13. On 3/14/13 at 4:00 p.m., the Administrator was informed of the issue. However, no other information or documentation was received from the facility.	C 664	Monitoring Executive Director is responsible to oversee that the facility meets infection control meetings rules. Executive Director will ensure that all required members of the infection control committee will meet together at least quarterly. Pharmacist will attend meetings via phone conference if unable to meet in person on the set meeting dates. Any issues or concerns that come up will be reported at our Performance Improvement Meeting for trending and further recommendations	
C 669	02.150,03 PATIENT/RESIDENT PROTECTION 03. Patient/Resident Protection. There is evidence of infection control, prevention and surveillance in the outcome of care for all patients/residents as demonstrated by: This Rule is not met as evidenced by: Refer to F315 as it related to prevention of urinary tract infections (UTI).	C 669	See POC for F 315	04/16/13
C 782	02.200,03,a,iv Reviewed and Revised	C 782		

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C 782	Continued From page 4 iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please see F 280 as it pertains to care plan revisions.	C 782	See POC for F 280	04/16/13
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 see F 309 as it pertains to pain and delay of treatment.	C 784	See POC for F 309	04/16/13
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Please see F 323 as it pertains to falls and supervision.	C 790	See POC for F 323	04/16/13
C 798	02.200,04,a MEDICATION ADMINISTRATION Written Orders 04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following:	C 798	See POC for F 281 and F 333	04/16/13

Bureau of Facility Standards

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C 798	Continued From page 5 a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule is not met as evidenced by: Please refer to F281 as it related to standards in medication administration.	C 798			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
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Boise, ID 83720-0009
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April 8, 2013

Gerald L. Bosen, Administrator
Kindred Nursing & Rehabilitation - Weiser
331 East Park Street
Weiser, ID 83672

Provider #: 135010

Dear Mr. Bosen:

On **March 14, 2013**, a Complaint Investigation survey was conducted at Kindred Nursing & Rehabilitation - Weiser. Nina Sanderson, L.S.W. and Linda Kelly, R.N. conducted the complaint investigation. This complaint was investigated during the annual Recertification and State Licensure survey conducted March 11, 2013, through March 14, 2013.

The following documentation was reviewed:

- An emergency room record dated February 1, 2013, for the identified resident (prior to the resident's admission to the long term care (LTC) facility);
- The identified resident's LTC facility clinical record, which included an initial nursing assessment, skin care, monitoring, treatment records and orders and interdisciplinary notes;
- The identified resident's progress notes dated February 21 through February 22, 2013, and a communication note to a physician dated February 22, 2013, by an assisted living facility (ALF);
- The clinical records of two other LTC residents identified with skin breakdown and/or pressure ulcers.

The following observations were made:

- The "bottom" or perineal and rectal area of two residents;

Gerald L. Bosen, Administrator
April 8, 2013
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- The heels, feet and lower extremities of two residents;
- Wound care and dressing change to the foot, heel and lower extremity of one resident.

Interviews were conducted with:

- Three Certified Nurse Aides (CNAs);
- Two Licensed Nurses (LNs); and,
- The Director of Nursing Services (DNS).

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005928

ALLEGATION #1:

The complainant stated an identified resident arrived at an area Assisted Living Facility (also known as an ALF) on February 21, 2013, at 12:30 p.m. and "a couple hours later" while being assisted to toilet; the staff discovered an open wound on the resident's "bottom" and on the resident's right heel, which was a quarter-sized blister with clear liquid.

The complainant stated the physician was notified and the resident was transferred to a local hospital approximately four hours later.

FINDINGS:

Review of the identified resident's LTC clinical record revealed there was redness in the perineal and rectal area when the resident was admitted to the LTC facility on February 1, 2013. In addition, redness and edema or swelling, in the resident's lower extremities was noted on the date of admission. Also, the perineal redness and lower extremity redness and edema persisted throughout the resident's stay in the facility. However, there was no documented evidence of open wounds on the resident's "bottom" or of a blister on either of the resident's heels from February 1, 2013, to February 21, 2013, at 10:30 in the morning when the resident was discharged. The resident left the LTC facility in a private vehicle for a 72-mile trip to an ALF in another town.

Review of the ALF documents revealed the identified resident was admitted to the ALF at 12:30 p.m., on February 21, 2013, which was two hours after the resident was discharged from the LTC facility. Then, three hours later at 3:30 p.m., a large, open wound was found on the resident's buttocks. Upon further skin check, a blister "about 2 (inches) long" was found on the resident's right heel.

Gerald L. Bosen, Administrator
April 8, 2013
Page 3 of 3

Note: There were at least five hours between the time the resident left the LTC facility and the ALF staff assessed the resident's buttocks and right heel. It is unknown if any pressure reduction devices were used when the resident traveled to the ALF. The possibility of skin deterioration occurring during the transport and first three hours at the ALF could not be ruled out.

Per the interview with the DNS, a skin check was completed within hours after the identified resident was admitted to the LTC facility and at twenty-four, forty-eight and seventy-two hours after admission. And, in an effort to avoid pressure, the resident's heels were floated starting at admission and throughout the resident's stay in the facility.

The resident's LTC facility clinical record contained documentation that the facility provided timely and appropriate care, which was consistent with the resident's diagnoses and co-morbidities.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,



LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj