



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: 7012 1010 0002 0836 1789

March 25, 2014

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

Provider #: 135014

Dear Mr. Holloway:

On **March 14, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Kindred Nursing & Rehabilitation - Caldwell 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.

Rick L. Holloway, Administrator
March 25, 2014
Page 2 of 4

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 7, 2014**. Failure to submit an acceptable PoC by **April 7, 2014**, may result in the imposition of civil monetary penalties by **April 28, 2014**.

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 will you 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 have 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.

Rick L. Holloway, Administrator
March 25, 2014
Page 3 of 4

- 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, 2014**, 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)

Rick L. Holloway, Administrator

March 25, 2014

Page 4 of 4

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

This request must be received by **April 7, 2014**. If your request for informal dispute resolution is received after **April 7, 2014**, 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 black ink that reads "David Scott, R.N.". The signature is written in a cursive style with a large initial "D" and "S".

DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj
Enclosures

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

PRINTED: 03/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2014
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHAB - CALDWELL			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual Federal recertification and complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Karen Marshall, MS RD LD Team Coordinator Rebecca Thomas, RN Lauren Hoard, RN BSN</p> <p>The survey team entered the facility on 3/10/14 and exited the facility on 3/14/14.</p> <p>Survey Definitions:</p> <p>ADLs = Activities of Daily Living AEB = As Exhibited By BWAT = Barbara Bates-Jensen Wound Assessment Tool BIMS = Brief Interview for Mental Status CAA = Care Area Assessment CNA = Certified Nurse Aide CM = Centimeters DDCO = District Director of Clinical Operations DNS/DON = Director Nursing Services/Director of Nursing D/T = Due to Dx = Diagnosis ED = Executive Director / Administrator IDT = Interdisciplinary Team LN = Licensed Nurse MDS = Minimum Data Set assessment MAR = Medication Record / Medication Administration Record PRN = As needed RAI = Resident Assessment Instrument SDC=Staff Development Coordinator</p>	F 000	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation - Caldwell does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p style="text-align: center;">RECEIVED MAY - 8 2014 FACILITY STANDARDS</p>		

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

TITLE

(X6) DATE

Rick L. Holroy

Executive Director

5/7/2014

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 000	Continued From page 1 TAR = Treatment Administration Record WC or W/C = Wheelchair	F 000	F164 RESIDENT RIGHTS		
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. 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 and resident interview, it was determined the facility failed to	F 164	1. Licensed nurses were counseled about the need to administer insulin to Resident #5 only in a private area. 2. All residents who receive injections, assistance with ADLs, treatments, and so on are potentially affected. 3. Licensed Nurse Staff will be re-educated by the Staff Development Coordinator (SDC) and/or Executive Director (ED) no later than April 11, 2014 regarding the established Kindred policy and state/federal requirements regarding resident rights to personal privacy to include by not limited to, location for privacy during injections. Additional staff education is provided upon hire and annually. 4. The ED and/or Director of Nursing (DNS) will conduct random reviews of common and/or non-private areas, during and around insulin administration times, starting the week of April 14, no less than three times per week for the next two (2) months, and once per week thereafter, to monitor for staff adherence to policies and procedures regarding resident rights to privacy. The results of this monitoring will be documented on the Performance Improvement (PI) audit tool. Any concerns will be addressed immediately and reported to the PI Committee. The PI Committee may adjust the frequency of monitoring after 12 weeks, as it deems appropriate.	4/14/14	

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F 164	<p>Continued From page 2</p> <p>ensure privacy was maintained when a subcutaneous injection was administered into a resident's shoulder in the hallway. This was true for 1 of 10 residents (#5) observed during medication pass observations. This failed practice created the potential for a negative effect on the resident's psychosocial well-being related to the need for privacy. Findings included:</p> <p>On 3/12/14 at 11:57 a.m., LN #5 wheeled Resident #5 in her wheelchair into the hallway outside of the Rose Room. The LN exposed the resident's left deltoid and administered 38 units of Novolin R insulin into the resident's left deltoid. During this time, Resident #20 was walking towards the resident and the LN in the hallway.</p> <p>Immediately afterward, the LN was asked if Resident #5 usually received her medication in the hallway near the Rose Room. The LN said she usually gives insulin in the resident's room and the other medication near the Rose Room because that is where Resident #5 spent most of her time.</p> <p>On 3/13/14 at 1:40 p.m., Resident #5 was asked if it bothered her when she received the insulin injection in her arm out in the hallway where people could see. She stated, "Not really" and added there were not many other places to go to receive the injection. The resident was asked had there been more places to go in private to receive the injection would she prefer it, the resident stated, "Yes." The resident was asked if she was aware of her right to privacy, she said, "Yes."</p> <p>On 3/14/14 at 11:00 a.m., the DON and DDCO were informed of the subcutaneous injection</p>	F 164		

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F 164	Continued From page 3 observation. However, no further information or documentation was provided which resolved the issue.	F 164			
F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, Policy and Procedure review and staff interviews, it was determined the facility failed to:</p> <ul style="list-style-type: none"> - ensure dining assistance was provided in such a way to maintain or enhance each resident's dignity, specifically staff stood while assisting residents to dine and - ensure staff treated a resident as an individual during transfers. This affected 2 of 9 sampled residents (#s 3 & 4) and 4 of 11 random residents (#s 16, 17, 18 & 19). This deficient practice created the potential to affect the residents' sense of well-being and self-worth. Findings included: <p>1. On 3/10/14 at 7:40 a.m., during the breakfast meal observation in the East dining room, Resident #16 was seated at a table with a bowl of hot cereal on the table in front of her. LN #2 was standing next to the resident while assisting the resident to dine. Immediately after the observation LN #2 acquired a stool and sat down next to the resident.</p> <p>On 3/12/14 from 5:22 until 5:24 p.m., during the</p>	F 241	<p>F241 DIGNITY AND RESPECT OF INDIVIDUALITY</p> <ol style="list-style-type: none"> 1. The Interdisciplinary Team (IDT) observed dining for resident #4, 16, 17, 18, & 19. Additional stools were placed for staff seating. ED and DNS provided re-education to Licensed nurses and CNAs regarding sitting while assisting residents to eat. Subsequent observations by the IDT reveal staff seated while assisting residents, including #4, 16, 17, 18, and 19 to eat. <p>The nurse management team observed staff transferring resident #3. The DNS provided re-education to the CNAs regarding communication with residents while providing care and assistance with ADLs, to include during mechanical lift transfers. Subsequent observations by the nurse management team reveal staff communicating with residents, including #4 during the lift transfer.</p> <ol style="list-style-type: none"> 2. All residents who require assistance with eating or ADLs have the potential to be affected. 	4/14/14	

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F 241	<p>Continued From page 4</p> <p>dinner meal observation in the East dining room, Resident #17 was seated at a table with a tan mug containing a brown thickened substance on the table in front of her. CNA #6 was standing next to the resident while assisting the resident to dine with bites of the thickened substance with a spoon.</p> <p>On 3/12/14 at 5:30 p.m., four residents were seated at a table in the East dining room. CNA #7 was standing while assisting Resident #19 to dine. After assisting Resident #19, the CNA turned and assisted Resident #18 to dine with three bites of food. Immediately after the observation CNA #7 was provided a stool and sat down.</p> <p>On 3/12/14 at 5:50 p.m., CNA #8 was observed standing while assisting Resident #19 to eat pudding and then drink from a cup.</p> <p>On 3/12/14 at 6:00 p.m., a surveyor asked CNA #8 about standing while assisting Random Resident #19 to dine. The CNA stated, "Today, I'm sorry. We don't have enough chairs to sit eye level. I know I should [sit at eye level while assisting residents to dine]."</p> <p>On 3/12/14 at 6:03 p.m., the DON was interviewed about staff standing while assisting residents to dine. He stated the staff, "Should be sitting" and provided the Policy and Procedure for Dining Standards.</p> <p>The Policy and Procedure for Dining Standards, dated 1/5/12, documented, "Staff sits down next to the patient while feeding and/or assisting with feeding."</p>	F 241	<p>3. Re-education will be provided by the SDC and/or ED no later than April 11, 2014 to licensed nurse staff and CNAs regarding provision of dignity and respect of individuality as established in Kindred policy, to include but not limited to,</p> <ul style="list-style-type: none"> • Staff to be seated during meal assistance • communication with residents while assisting them with ADL's, to include during mechanical lift transfers. <p>Additional staff education is routinely provided upon hire and annually; increased education for dignity to include sitting while assisting to eat and resident communication while using the mechanical lift will be provided quarterly. Nurse management rounds will observe for compliance and correct deficient practice immediately if observed.</p> <p>4. The ED and/or designee, will conduct random dining room observations starting the week of April 14 no less than three times per week for the first two months, and once per week thereafter, to monitor staff compliance with this policy. The DNS and/or designee, will monitor assistance with ADL's provided to residents at least three times per week for the first two months, and once per week thereafter, to monitor compliance with this policy. The results of this monitoring will be documented on the PI audit tool. Any concerns will be addressed immediately and reported to the PI Committee. The PI Committee may adjust the frequency of monitoring after 12 weeks, as it deems appropriate.</p>		

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F 241	<p>Continued From page 5</p> <p>2. On 3/10/14 at 12:35 PM, during the lunch meal observation in the Rose Room, LN #5 was observed standing over Resident #4 while assisting the resident to dine. A staff member came into the Rose Room and told LN #5 a resident was requesting a pain pill. LN #5 then asked CNA #11 to take over assisting Resident #4. CNA #11 obtained a stool, sat down and assisted the resident to dine.</p> <p>On 3/13/14 at 2:35 PM, LN #5 was interviewed about standing while assisting Resident #4 to dine. LN #5 stated, "Resident #4 was having a struggle while eating so I gave her three bites...I knew the minute I did it [stood while she was eating] that I shouldn't have but she [the resident] was having a lot of problems that day."</p> <p>3. Resident #3 was admitted to the facility with multiple diagnoses including, dementia with behavior disturbances, paralysis agitans, and secondary Parkinsonism.</p> <p>The resident's 3/3/14 annual MDS coded severe cognitive impairment, totally dependent for ADLs, two person physical assistance with bed mobility and transfers, and mobility device was a wheelchair.</p> <p>The resident's 1/28/14 Idaho Physician Orders for Scope of Treatment (POST) documented, in part, comfort measures only.</p> <p>The resident's 3/5/14 Care Plan documented the 12/10/08 problem area of impaired physical mobility. Problem approaches included, "...Broda chair w/c main mode of transporion {sic}...bed mobility with extensive assist of 2...hoyer transfer with 2 assist...use drawsheet in w/c to assist with</p>	F 241			

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F 241	<p>Continued From page 6 positioning."</p> <p>On 3/11/14 from 12:15 to 12:26 p.m., CNA # 9 and CNA #10 were observed transferring the resident from the bed to a Broda chair. The CNAs turned the resident onto the resident's right side using a drawsheet, placed the hoyer sling under the resident's left side, moved the resident from her right to her left side and positioned the hoyer sling under the other side of the resident's body. The resident was then positioned on her back and when CNA #9 released her grip on the drawsheet, the upper right corner of the drawsheet landed on the resident's face. The drawsheet covered approximately 75% of the resident's face. CNA #9 then lifted the corner of the drawsheet off the resident's face. CNA #9 released her grip on the drawsheet and the corner of the drawsheet landed on the right side of the resident's face. The corner of the drawsheet covered the resident's right cheek and right side of the chin.</p> <p>Note: During this part of the observation, the CNAs did not attempt to speak to the resident about what they were doing such as turning the resident onto her right and then onto her left side. When the drawsheet landed on the resident's face, CNA #9 did not make any comments to the resident.</p> <p>The CNAs attached the hoyer sling to the hoyer. CNA #10 said, "Going up." The hoyer lifted the resident out of her bed and the CNAs moved the hoyer with resident beside the resident's Broda chair. The resident's head was positioned over the foot of the Broda chair and the resident's feet were positioned over the head of the Broda chair. The CNAs turned the resident 180 degrees and</p>	F 241			

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F 241	Continued From page 7 then lowered the resident into the Broda chair. Note: When the CNAs turned the resident 180 degrees, the CNAs did not speak to the resident about what they were doing or why they were turning the resident 180 degrees while in the hoyer sling. On 3/12/14 at 11:50 a.m., the surveyor interviewed the DON and the District Director of Clinical Operations about the 3/11/14 from 12:15 to 12:26 p.m. observation of 2 CNAs transferring Resident #3 from the bed to a wheelchair. As the DON listened to the surveyor's observation, the DON moved his head from side to side. On 3/13/14 at 10:19 a.m., CNA #10 was interviewed about the 3/11/14 from 12:15 to 12:26 p.m. observation. The CNA stated, "I said going up, putting in hoyer." The surveyor then asked the CNA how the CNA was trained to talk with residents when providing cares. The CNA stated, "We were trained to tell the resident what you are doing as you do it. I try to communicate with [Resident #3] when doing cares." On 3/13/14 at 10:21 a.m., CNA #9 was interviewed about the 3/11/14 from 12:15 to 12:26 p.m. observation. The CNA stated, "We did tell her we are lifting you, we are putting you in the hoyer." The surveyor then asked the CNA how the CNA was trained to talk with residents when providing cares. The CNA did not offer a response. On 3/14/14 at 1:00 p.m., the Administrator was informed of the observation on 3/11/14.	F 241			
F 257	483.15(h)(6) COMFORTABLE & SAFE	F 257			

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

PRINTED: 03/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2014
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F 257 SS=E	<p>Continued From page 8 TEMPERATURE LEVELS</p> <p>The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F</p> <p>This REQUIREMENT is not met as evidenced by: Based on individual resident interview, Resident Group interview, ambient temperature evaluation, hard surface temperature evaluation, and staff interview, it was determined the facility failed to provide comfortable temperatures levels. This affected 1 of 9 (#9) sampled residents, 5 of 15 (30%) of residents who attended the Resident Group interview and had the potential to affect the residents who resided on the 200 hallway East side of the facility. This practice created the potential for residents to self-isolate in their rooms in an effort to keep warm. Findings included:</p> <p>On 3/11/14 at 8:45 a.m., Resident #9 stated, "My room is too cold, the building is too cold. I have to wear my jacket all the time to stay warm."</p> <p>On 3/11/14 the Maintenance Supervisor and the surveyor evaluated the temperatures on the East side and West side of the building as follows:</p> <p>* 9:05 a.m. Resident #9's room, The inside of the exterior concrete block wall was "65.0 degrees Fahrenheit (* F)." The floor was "67.5* F." The ambient room temperature (temp) was "69.6* F."</p> <p>* 9:15 a.m., East dining room: The ceiling temp was "69.5* F." The floor was "68.0* F." The inside</p>	F 257	<p>F257 ENVIRONMENT</p> <ol style="list-style-type: none"> 1. The temperature in resident #9's room was immediately adjusted when the surveyors were in the building. Subsequent observations reveal temperatures between 73 and 78 or adjustments to the heating unit controller are made to address the ambient temperature. Upon interview, resident #9 states that she is comfortable with her room temperature. 2. All residents have the potential to be affected by ambient temperatures even slightly below 71 degrees F. 3. The Maintenance Director was educated by the ED regarding facility temperature range is required to be 71-81 degrees F. Maintenance rounds will assess room temperatures in two random resident rooms on the East wing and two random resident rooms on the West Wing at least weekly, paying close attention to mornings where the external temperature drops below 40 degrees. Rooms reviewed will be rotated for random monitoring. Immediate adjustments to the heating unit controllers if temperatures are found below 73 degrees will occur. It should be noted that, during the previous three months of Resident Council meetings spanning through December, January, and February, no resident complained that any part of the facility was too cold. 	7/14/14	

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

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F 257	<p>Continued From page 9</p> <p>of the exterior concrete block wall was "67.0* F." The inside wall dividing the dining room from the 200 hallway was "70.0* F." A dining room table top was "69.5* F." The ambient room temp was "69.5* F."</p> <p>* 9:17 a.m., Rose dining room: The ceiling and floor temps were "67.5* F." The inside of the exterior concrete block wall was "64.5* F." A dining room table top was "68.5* F." The ambient room temp was "69.1* F."</p> <p>On 3/11/14 at 9:24 a.m., the 200 hall thermostat was observed set at 70.0* F. The Maintenance Director stated, "I can turn the temperature up." At 9:34 a.m., the 200 hall thermostat was blinking 74.0* F.</p> <p>On 3/11/14 at 10:20 a.m., the 15 residents who attended the Resident Group interview were asked, "Is the temperature in the building comfortable for you?" Five out of the 15 (30%) residents said, "Too cold." Four of the other 10 residents said, "Fine." One of the other 6 residents said the East side of the building was not as warm as the West side of the building. The remaining 5 residents did not offer a reply to the question about the temperature in the building.</p> <p>On 3/14/14 at 1:00 p.m., the Administrator was informed of the concern.</p>	F 257	4. The weekly room and building temperature check sheets will be maintained by the ED and/or Maintenance Director starting the week of April 14, 2014. The results of this monitoring will be documented on the PI audit tool. Any concerns will be addressed immediately and reported to the PI Committee. The PI Committee may adjust the frequency of monitoring after 12 weeks, as it deems appropriate.		
F 280 SS=D	<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</p>	F 280			

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

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F 280	<p>Continued From page 10 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 record review and staff interview, it was determined the facility failed to ensure the care area triggered by the RAI process was care planned and updated as identified in the CAA. This was true for 1 of 9 (#2) residents sampled for the RAI process. This practice created the potential for harm due to the lack of direction in the care plan. Findings included:</p> <p>Resident #2 was admitted to the facility on 9/11/12 with multiple diagnoses including congestive heart failure, GERD (gastroesophageal reflux disease), blindness secondary to diabetes mellitus.</p> <p>The most recent Annual MDS Assessment, dated 7/17/13, and the most recent Quarterly MDS Assessment, dated 10/16/13, both documented the resident needed assistance of one person for</p>	F 280	<p>F280 RIGHT TO PARTICIPATE IN CARE PLANNING-REVISE CARE PLAN</p> <ol style="list-style-type: none"> Resident #2's care plan has been updated to reflect dental care related to the proper use of denture adhesive. All residents requiring oral care have the potential for being affected by this practice. Clinical management team reviewed residents whose MDS trigger for dental care, care plans have been adjusted as indicated. Licensed Nurse Staff and the MDS Coordinator will be inserviced by the SDC and/or designee no later than April 11, 2014 regard care planning for items that trigger on the MDS, to include but not limited to dental care. The DNS and/or designee will review dental care plans starting the week of April 14 for no less than 4 residents per week. New admission residents, residents with a change of condition, and residents with a quarterly review will determine resident records for review. The results of this monitoring will be documented on the PI audit tool. Any concerns will be addressed immediately and reported to the PI Committee. The PI Committee may adjust the frequency of monitoring after 12 weeks, as it deems appropriate. 	4/14/14	

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

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F 280	Continued From page 11 personal hygiene. The Annual MDS Assessment, dated 7/17/13, documented in Section V the Dental Care Area triggered and was care planned. Review of the 7/19/13 Care Area Assessment for the oral/dental condition/problem documented the resident was at risk for oral ulcers and sores from loose dentures. The Care Plan Considerations column documented, "CP [care plan] for denture adhesive and assist with oral care." Record review did not provide evidence a care plan was developed for oral/dental condition/problem. On 3/14/14 at 9:05 AM, the MDS Coordinator was interviewed and asked if a care plan had been developed for the oral/dental condition/problem. The MDS Coordinator stated he would check into it. On 3/14/14 at 9:25 AM, the MDS Coordinator stated he did not find a dental care plan. He stated, "He asked the aides how they knew to use denture adhesive and assist with oral care and the aides told him they just knew to do that." He then stated, "Sorry, I guess I missed that." On 3/14/14 at 11:00 AM, the DON, Administrator and the DDOC were made aware of care plan concerns. The facility did not provide any further documentation.	F 280			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309			

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

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F 309	Continued From page 12 or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to provide the necessary care and treatment for residents to attain or maintain their highest practicable well-being. This was true for 2 of 13 (#4 & #3) residents sampled for quality of care. Resident #4 was harmed when a venous ulcer increased in size due to improper Unna Boot application. Resident #3's care plan was not updated to include comfort measures. This placed the resident at risk for unmet needs related to comfort measures. Findings included: 1. Resident #4 was admitted to the facility on 3/29/13 with multiple diagnoses which included hypothyroidism, diabetes mellitus type II, vascular dementia, bipolar disorder, and osteoporosis. The 7/3/13 Significant Change in Status MDS and the 10/2/13 Quarterly MDS Assessment, both, documented the resident: *had moderate cognitive impairment; and, *had functional limitation in range of motion with impairment to both sides of her lower extremities. Both assessments documented the use of a wheelchair, however, the 7/3/13 assessment included the use of a walker.	F 309	F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 1. At the time of survey, as noted in the CMS-2567 resident # 4 currently had her Unna boot applied as per manufacture directions. Her care plan was updated to include wound oversight by the wound clinic, Unna boot per MD orders, prevalon boot to RLE, and tubigrips to LLE. Subsequently the Unna boot has been discontinued and the stasis ulcers are healed. The care plan for resident #4 is again updated to discontinue treatments, continue tubigrips size E to BLE while up, and return to wound clinic in 6 weeks for edema check. Resident # 3 care plan is updated to address her change in status and comfort care as indicated. 2. No other residents have orders for Unna boots. As noted in the CMS-2567, the SDC received education on Unna boot application at the wound clinic by the physical therapist. The SDC then applied the Unna boot to the resident during dressing changes at the center. Clinical management team reviewed residents with current skin issues and change in condition requiring comfort care, care plans have been adjusted as indicated.	4/14/14	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 13</p> <p>The 7/5/13 Progress Notes documented a MDS nursing and social service note the resident was showing a cognitive decline and was more forgetful and confused. Additionally, the resident had an increase in urinary incontinence and decrease in physical functioning due to increased difficulty with ambulation and required a WC for mobility and staff to propel majority of the time.</p> <p>The resident's care plan, dated 3/29/13, for the problem of "Self Care Deficit: ADL's [activities of daily living] related to deteriorating physical condition" documented in part: Uses w/c (wheelchair) for mobility, encourage to propel self, and was a 2 person transfer.</p> <p>The resident's care plan, dated 3/29/13, for the problem of "Skin/Tissue Integrity Impaired: Potential related to history of vascular ulcer and fragile skin of past ulcer site" documented in part: *weekly skin checks by LN (licensed nurse); *assure footwear is protective and fits well during weekly LN skin check *float heels on pillows when in bed; and, *tubigrip size D (or indicate which leg).</p> <p>NOTE: The care plan did not contain documentation that the resident went to a wound clinic, wore an Unna Boot and a Prevalon boot on the right lower extremity or wore a tubigrip dressing on the left lower extremity.</p> <p>The resident's Patient Nursing Evaluation on admission, dated 3/29/13, documented, on page 2 under skin inspection, the resident was admitted to the facility with five non-pressure ulcers on the outer right ankle. There was documentation the skin was warm, dry and intact with frail, scaly skin on the outer right ankle from</p>	F 309 3.	<p>Licensed Nurse Staff will be inserviced by SDC and/or DNS no later than April 11, 2014 regarding provision of care and services, to included but not limited to</p> <ul style="list-style-type: none"> • update of care plans for prevention and healing of wounds, • weekly wound measurement that reflect wound progress/deterioration, • timely referral for advanced wound care as indicated, • clarification of the Unna boot policy, (no current residents have an Unna Boot order, re-education will be provided by the SDC with skills checks return demonstration completed by the licensed nurse prior to implementation of orders for Unna Boots on any resident) and • address residents with decline to individualize their care plans for comfort measures. <p>Additional staff education is provided on wound prevention and management upon hire and annually. New process or wound techniques will be educated to by the SDC and skills checks completed by licensed nurse staff prior to resident implementation.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 14</p> <p>history of vascular ulcer with the following measurements measuring distal to proximal: *1 x 0.5 cm; *0.3 x 0.1 cm; *1 x 0.4 cm; *0.3 x 0.2 cm; and, *0.8 x 0.7 cm.</p> <p>The resident's Weekly Non-Pressure Skin Condition Report documented the right ankle wounds gradually decreased in size and were last measured on 4/25/13 from distal to proximal: *0.2 x 0.1 (cm); *0.2 x < 0.1 (cm); *0.2 x 0.2 (cm); and, *0.2 x 0.1 (cm).</p> <p>NOTE: The medical record did not contain measurements of the right ankle wounds after 4/25/13 or document the wounds had healed.</p> <p>On 3/13/14 at 9:50 AM, the SDC was interviewed regarding the timeline of events of the right ankle measurements. She stated the measurements of the venous ulcers should have been measured weekly but the last measurements she could find were taken on 4/25/13. The next measurement was taken on 6/2/13, for one wound on the right ankle, and was not included on a Weekly Non-Pressure Skin Condition Report. There were no other wound measurements except for one right ankle wound. Additionally, the SDC stated the resident became ill and missed two visits to the Wound Clinic in September. During this time, the SDC measured the right ankle wound which increased in size as a result of being ill.</p> <p>The resident's progress notes, dated 5/24/13, documented a condition change by LN #4, "Ulcer</p>	F 309	<p>4. The DNS and/or designee will review 2 residents per week starting the week of April 14 for necessary care and treatment of wounds to include but not limited to</p> <ul style="list-style-type: none"> • Skills demonstrated for implementation of physician orders, to include proper layering of Unna boot wraps • -wound measurements documented weekly, • physician is notified for wound directives every 2 weeks if wound does not show improvement. Request for referral for advanced wound care is requested if wound directives do not improve wound or if wound deteriorates • documentation of dressing changes per physician orders are evident on the Treatment Administration Record (TAR) • Accurate physician order transcription to the TAR for documented evidence of implementation. • care plan is updated to include nursing interventions as well as physician orders <p>One resident per week will have record reviewed for care plan updates with change of condition to include comfort care. The results of this monitoring will be documented on the PI audit tool. Any concerns will be addressed immediately and reported to the PI Committee. The PI Committee may adjust the frequency of monitoring after 12 weeks, as it deems appropriate.</p>		

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F 309	<p>Continued From page 15</p> <p>on right outer ankle is not improving with current treatment. It is now 0.5 [cm] x 0.5 [cm] x 0.1 [cm]...May we have an order for a new treatment."</p> <p>The medical record contained a physician's telephone order, dated 5/24/13: (1) DC [discontinue] Lotrisone (2) Bactroban Ointment to ulcer cover with island dressing, [change] everyday (3) Prevalon boot when in bed"</p> <p>A progress note, dated 6/2/13, documented by LN #2, the wound had increased in size, "R [right] lower lateral skin wound with partial thickness loss of skin involving epidermis, edges distinct with cream colored wound base. Size 0.7 [cm] x 0.5 [cm] x 0.1 cm with slight cratered base. Scant serosanguinous exudate, surrounding tissue dark red/purple consistent with venous insufficiency...Please advise with consideration of wound consult."</p> <p>On 6/15/13, LN #1 received a telephone order, from the resident's physician, to make an appointment [with a local wound care center] for the wound to R [right] ankle."</p> <p>The resident's physician's Nursing Home Visit note, dated 6/25/13, documented, "dressing changes were not showing signs of improvement so expertise was needed as this has been a chronic wound and she has been seen by the [local wound clinic] in the past."</p> <p>NOTE: The order for the local wound clinic was received 13 days after the request, 6/2/13 to 6/15/13.</p>	F 309			

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

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F 309	<p>Continued From page 16</p> <p>A Wound Care Initial Evaluation, with a date of service of 6/27/13, documented the Chief Complaint was evaluation of a venous stasis ulcer of the right lateral malleolus. The evaluation documented the resident had not been seen for a couple of years but had developed a "new recurrent area of ulceration over the right lateral malleolus." The wound measured Length 1.4 cm x Width 0.9 cm x Depth 0.2 cm. The Plan included in part:</p> <ul style="list-style-type: none"> *(1) PolyMem Silver dressing with a cover three times per week and, as needed; *(2) Physical Therapy to evaluate; and, *(3) Recheck the resident in two weeks or sooner for worsening, new symptoms or other concerns. <p>On 7/11/13 a Wound Care Progress Report documented the resident was seen for follow-up evaluation for the right lateral malleolus. The skin wound examination documented the wound measured Length 0.7 cm x Width 0.9 cm x Depth 0.1 cm. The wound was debrided and Unna Boots were placed bilaterally. The Plan included in part:</p> <ul style="list-style-type: none"> *(1) Promogran and PolyMem Ag dressing with cover changed twice weekly. *(2) Bilateral lower extremity Unna Boot wraps per physical therapy. *(3) Unna Boot wraps should be changed twice weekly. *(4) Recheck in 2 weeks or sooner for worsening conditions, signs or symptoms of infection, complications, concerns or questions. <p>The Treatment Record for July, 2013, documented the facility changed the Unna Boots bilaterally on 7/13/13, 7/17/13, 7/21/13, and 7/22/13.</p>	F 309			

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHAB - CALDWELL		STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
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F 309	<p>Continued From page 17</p> <p>NOTE: The Unna Boot order was to change the wraps twice weekly. However, the week of the 7/21/13 the wraps were changed on two consecutive days, 7/21 and 7/22.</p> <p>NOTE: The resident's care plan did not identify the use of the Unna boots and did not include the approach of a schedule for when to change the Unna boots.</p> <p>The resident's next visit to the Wound Center was on 7/25/13. The Wound Care Progress Note documented, "the compression wraps were improperly applied today. There is some concern that staff may not have the appropriate education to apply these dressings." Additionally, there was documentation, "a new and very small area of superficial ulceration appreciated at the left medial gaiter region. This may be associated with her improperly applied wraps." Measurements of the right lateral malleolus documented the Length 1.6 cm x Width 1.4 cm x Depth 0.1 cm. The left medial malleolar region examination documented the wound measured Length 0.6 cm x Width 0.8 cm x Depth less than 0.1 cm. The Plan included in part:</p> <ul style="list-style-type: none"> *(1) Dressings of Aquacel-Ag and cover changed twice weekly or as needed for soilage or drainage. *(2) Compression wraps to the bilateral lower extremities for edema management. *(3) Patient to return to clinic twice weekly for dressing changes with nursing and physical therapy. *(4) Bring staff to learn wrap method at these dressing changes. <p>The medical record documented a telephone</p>	F 309		

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

PRINTED: 03/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2014
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F 309	<p>Continued From page 18</p> <p>order for the resident "to return to clinic 2 X [times] week for drsg/unnaboot application until facility staff able to come to clinic to learn proper unna boot technique."</p> <p>A Progress Note, dated 7/25/13, by the SDC documented the resident was "out to wound clinic for follow up wound on Rt ankle is improving."</p> <p>NOTE: The wound actually increased in size from 7/11/13 to 7/25/13.</p> <p>On 7/29/13, the SDC returned to the Wound Center with the resident for education on proper technique for Unna Boot application.</p> <p>On 3/12/14 at 12:30 PM, the SDC was interviewed and said the resident returned with Unna Boots bilaterally on 7/11/13 from the Wound Clinic. She also said, she pulled the facility policy and procedure for Gelocast (Unna Boot) Application and gave it to LN #2 and LN #4, the nurses who would be applying the Unna Boots. At that point they told her they knew how to apply Unna Boots. The SDC stated she only became involved with the resident when the Wound Clinic determined the Unna Boots were improperly applied on 7/25/13. She stated she went to the Wound Clinic on 7/29/13 for education on how to apply Unna Boots and became the designated person to apply the Unna Boots.</p> <p>On 3/13/14 at 8:20 AM, the SDC was interviewed and stated she remembered a conversation where the nurses were talking about how to wrap the impregnated gauze (Unna Boot). She remembered the nurses discussed they had seen it wrapped both ways - meaning (1) the impregnated gauze was wrapped directly next to</p>	F 309		

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

PRINTED: 03/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2014
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F 309	<p>Continued From page 19</p> <p>the skin followed by dry gauze/padding, and (2) dry gauze/padding was placed directly next to the skin followed by the impregnated gauze.</p> <p>On 3/13/14 at 11:10 AM, the surveyor and the SDC reviewed the policy and procedure for Unna Boot Application. The list of equipment did not include gauze, which was mentioned in Step 17 in the procedure column. It was unclear whether or not this was the Unna Boot dressing. Additionally, the procedure did not mention medicated gauze, dry gauze or cast padding, coban or ace bandage after Step 17 of the procedure column. The SDC agreed the terminology varied throughout the policy and was unclear. She stated she would bring it to the DDCO's attention. Additionally, she agreed the resident's care plan for skin integrity did not contain approaches for Unna Boots or a Prevalon Boot. The SDC stated those should have been updated and approaches should have been care planned.</p> <p>On 3/13/14 at 1:45 PM, the surveyor observed the SDC apply the Unna Boot to the resident's right lower extremity and noted the Unna Boot box documented directions for the correct application of Unna Boots.</p> <p>A progress note, dated 1/29/14, documented "resident to wound clinic and returned; res [resident] not to wear it [right shoe], is to wear Prevalon boot at all times." However, the Physician's Orders (recap orders) for the month of February and March of 2014, documented an order for the resident to wear a Prevalon boot when in bed, rather than at "all times," with a start date of 5/24/13.</p> <p>On 3/13/14 at 3:15 PM, the DON stated he was</p>	F 309			

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

PRINTED: 03/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2014
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F 309	<p>Continued From page 20</p> <p>aware the policy and procedure for Unna Boots needed to be updated. The DON was made aware the resident was to wear the Prevalon boot at all times, not only when in bed as ordered on the Physician's Orders (recap orders). The DON stated understanding.</p> <p>On 3/14/14 at 10:20 AM, the DON was interviewed regarding the Unna Boot Application. He stated he had never applied Unna Boots. He stated when it was identified we were doing it wrong, the SDC was appointed to go to the Wound Clinic to learn how to apply them. When asked if the policy and procedure for Unna Boots was updated after it was discovered the staff had applied the Unna Boots incorrectly. The DON stated it did not occur to him to change the policy. The DON was made aware the directions for the Unna Boots application was listed on the box and the DON stated understanding.</p> <p>The resident was harmed when the facility failed to provide the necessary care and treatment for Resident #4:</p> <ul style="list-style-type: none"> - when the facility did not educate staff on the proper application of Unna Boots bilaterally over a two week period. The right ankle wound increased in size and a new ulceration was found on the left ankle. As a result, the Wound Clinic requested the resident return to the Wound Clinic for the proper application of Unna Boots and requested staff come to the Wound Clinic to learn proper Unna Boot technique. - when the policy and procedure for Unna Boot Application was unclear and the terminology varied throughout the policy. As a result, the Unna Boot was not applied correctly. - when the care plan was not revised to include the resident went to a wound clinic, wore Unna 	F 309			

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

PRINTED: 03/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2014
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F 309	<p>Continued From page 21</p> <p>Boots, needed to wear a Prevalon Boot, wore a tubigrip dressing on the left lower extremity, and did not include a schedule for when to change the Unna boots.</p> <p>-when the facility did not ensure the Physician Orders (recap orders) included an order for a Prevalon Boot to be worn at all times.</p> <p>On 3/14/14 at 10:35 AM, the DON, Administrator and DDCO were informed of the quality of care concerns regarding the improper Unna Boot Application and the increased size of the right lateral malleolus when the Unna Boot was applied improperly.</p> <p>On 3/14/14 at 11:05 AM, the DDCO stated she agreed the Unna Boots were not applied correctly.</p> <p>On 3/17/14 at 2:15 PM, the facility faxed additional information, however, the information provided did not resolve the issue.</p> <p>2. Resident #3 was admitted to the facility with multiple diagnoses including, dementia with behavior disturbances, paralysis agitans, and secondary Parkinsonism.</p> <p>The resident's 3/3/14 annual MDS coded severe cognitive impairment, totally dependent on staff for ADLs, and always incontinent of bowel and bladder.</p> <p>The resident's 1/28/14 Idaho Physician Orders for Scope of Treatment (POST) documented do not resuscitate (DNR), comfort measures only, trial intravenous fluids, antibiotics, and pain treatment.</p>	F 309			

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

PRINTED: 03/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2014
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F 309	<p>Continued From page 22</p> <p>The resident's physician Nursing Home Visit reports documented, in part, the following:</p> <ul style="list-style-type: none"> - 10/1/13, "...does not attempt to speak...advanced dementia...Parkinson's disease...used to be much more mobile and verbal...outlook...exceedingly poor..." - 12/19/13, "...end-stage Parkinson disease and dementia...nonverbal most this time...requires total care...dementia is advancing...does not really awaken for the examination..." - 1/30/14, "...requires total care...completely immobile...not as verbal as...used to be and the aids and staff anticipate...needs...condition...declining...severely debilitated...DNR with comfort measures...ongoing decline...not going to improve...extremely stiff...very immobile..." - 2/11/14, "...decline in...status...in...last days...decreased movement, decreased ability to swallow, cough, eat...ongoing difficulties...do not think...imminently terminal, but...definitely in the last months...prognosis of 6 months or less..." <p>The resident's 3/5/14 Care Plan (CP) was reviewed. The CP identified problems, goals, and problem approaches. For example:</p> <ul style="list-style-type: none"> - Problem: Self-Care Deficit: Hygiene. Three of the six problem approaches were, "Allow ample time for tasks...May become resistive with accepting help with ADL's (sic) and require re-approach...Staff use a gentle approach and encourage to accept assistance." - Problem: Anxiety. Three of the eight problem approaches were, "...Acknowledge health care complaint and consult with appropriate 	F 309			

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

PRINTED: 03/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2014
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F 309	<p>Continued From page 23</p> <p>professional...Encourage discussion of fear/anxiety. Allow to cry. Report tears/crying...Redirect focus from self by providing diversional act [activity]..."</p> <p>- Problem, Coping, Ineffective, Individual. Four of the five problem approaches were, "Encourage resident to reminisce and review life to identify past coping skills...Group activities to establish trust relationship. Allow to discuss feelings of fear and frustration. Encourage to discuss feelings about placement in LTC [long term care] facility, physical condition, loss of independence...Offer positive feedback when effective coping skills are used..."</p> <p>- Problem, Verbal Communication, Impaired. One of the three problem approaches was, "...Encourage to communicate slowly & to repeat requests. Do not rush..."</p> <p>- Problem, Resident at risk for falls. One of the nine problem approaches was, "Orient to surroundings & room number as frequently as needed."</p> <p>- Problem, Self-Care Deficit: Bathing/Showers. Three of the seven problem approaches were, "...Allow ample time for tasks...Praise efforts, successes & general appearance...Set up bathing supplies. Encourage to complete task and assist as needed."</p> <p>- Problem, Self-Care Deficit: Dressing/Grooming. The two problem approaches were, "Allow ample time for tasks. Allow to make choices RE: clothing selection."</p> <p>Note: The resident's CP was not individualized or updated to reflect the actual status of the resident for comfort measures.</p> <p>Federal guidance at F309 indicated, in part, "...Care Plan Revision...based upon the</p>	F 309			

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

PRINTED: 03/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2014
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F 309	Continued From page 24 following...Change in resident condition, ability to make decisions, cognition, medications, behavioral symptoms or visual problems..." On 3/11/14 at 1:57 p.m., the resident's physician was interviewed. The physician said the resident was on comfort measures and no heroic measures were to be taken. The resident was not on comfort cares to the point of discontinuing medications, just comfort measures. On 3/12/14 at 2:55 p.m., the surveyor discussed with the DON and the District Director of Clinical Operations the resident's physician Nursing Home Visits documented the resident's on-going decline and imminently terminal status however the CP did not reflect the resident's comfort measures. The surveyor shared with the DON the above identified approaches that did not reflect the resident's current ability or status. The DON acknowledged the CP should have been updated to reflect what the facility does for the resident's "comfort measures."	F 309			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	F314 TREATMENT/SERVICES TO PREVENT/HEAL PRESSURE ULCERS 1. Resident # 1 and 3 have current care plans and healing wounds as indicated in the CMS-2567. No additional changes to care were implemented as the plan was effective at the time of the survey. Resident #1 and 3 wounds were cited as they occurred in the center.	4/14/14	

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

PRINTED: 03/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2014
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F 314	<p>Continued From page 25</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure residents who entered the facility without a pressure ulcer did not develop pressure ulcers for 2 of 6 sample residents (#s 1 and 3) reviewed for skin conditions. The deficient practice resulted in residents developing avoidable pressure ulcers. Findings included:</p> <p>1. Resident #1 was admitted to the facility with multiple diagnoses which included Alzheimer's type dementia and constipation.</p> <p>Resident #1's admission MDS, dated 2/18/13, documented in part: * Severely impaired cognition; * Extensive assistance needed with 2 or more people for bed mobility and toilet use; * Extensive assistance needed with 1 person for walking in room and corridor, locomotion on and off the unit, dressing, eating, personal hygiene and bathing; * Limited assistance needed with transfers; * Used a wheelchair; * At risk of developing pressure ulcers; and, * No unhealed pressure ulcers.</p> <p>Resident #1's Occupational Therapy (OT) Evaluation, dated 6/27/13, documented: * Reason for Referral, "Pt [patient] is leaning back [with] w/c [wheelchair], head/neck are weak. She needs improved w/c positioning;" * Justification for Skilled Services, "OT to address w/c positioning, head/neck positioning, ROM [range of motion], strengthening and pain mgmt</p>	F 314	<p>2. Clinical management team reviewed residents with current skin issues, wound measurements are complete and care plans have been revised for prevention based on Braden score risk factors and to address root cause. Investigation of future wounds will include documentation of additional interviews that determine root cause; plan of care will be based on root cause.</p> <p>3. Licensed Nurse Staff will be inserviced by SDC and/or DNS no later than April 11, 2014 regarding prevention and treatment of pressure ulcers, to included but not limited to weekly wound measurement that reflect wound progress/deterioration, update to care plan interventions upon identification of the wound and with changes as they occur, documentation that depicts the investigation interviews to determine root cause of wounds, the impact of friction with tone and wheelchair position, and the prevention of abrasions over scar tissue during repositioning. Additional staff education is provided on wound prevention and management upon hire and annually.</p>		

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

PRINTED: 03/25/2014
FORM APPROVED
OMB NO. 0938-0391

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F 314	<p>Continued From page 26 [management];" * Summary Statement, "...She currently gets total [assist] for all cares. Max [assist] x 2 for transfers. She has been extending head/neck back in w/c and not able to keep it upright. She is in a highback tilt back w/c [with] pillow 18x16 [with] a saddle cushion currently. She may benefit from a 16 [inch] w/c [with] supports to armrests. Her chair is not supporting her back appropriately either;" and, * Long Term Goals, "1. Improved w/c positioning to [decrease] pain and improve posture for mealtimes 2. Improve UE [upper extremity] strength to...[assist with] self feeding skills 3. Pt to be mod[erate assist] for self feeding."</p> <p>An Occupational Therapy Discharge Summary for Resident #1, dated 7/10/13, documented a summary of skilled services and significant progress as, "Pt's treatment this past week focused on assessment of w/c system, self feeding staff education. Excellent carry over with positioning..." Significance of status documented, "W/C positioning completed, pt not able to feed herself [at] this time. Pt is supported in all areas and careplanned for w/c positioning." The Discharge Recommendations was documented, "Wheelchair seating system: Pt in recline back w/c [with bilateral] elevating leg rests."</p> <p>The Care Plan for Resident #1, dated 3/7/14, documented a Problem of Skin/tissue integrity impaired: Potential related to dementia/confusion, pain, incontinence and constipation. The Approaches documented were to: * Turn and position side to side when in bed. Avoid skin on skin contact. use pillows as needed (1/2/14); * Avoid friction and shearing. Use turn sheet for</p>	F 314	4. The DNS and/or designee will review 2 residents per week starting the week of April 14 for prevention of wounds related to potential friction, weekly wound measurements, documentation of investigation if indicated, and care plan updates to reflect current plan of care. The results of this monitoring will be documented on the PI audit tool. Any concerns will be addressed immediately and reported to the PI Committee. The PI Committee may adjust the frequency of monitoring after 12 weeks, as it deems appropriate.	

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

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F 314	<p>Continued From page 27</p> <p>repositioning (2/12/13);</p> <ul style="list-style-type: none"> * Daily skin inspection during cares. Notify LN of skin integrity impairments (2/12/13); * Weekly skin checks by LN (2/12/13); * Alternating air mattress set at 5 (1/2/14); * Roho cushion with RNA (Restorative Nurse Aide) check daily for proper inflation (2/14/14); and, * Last up first down (2/14/14). <p>On 8/5/13 a Weekly Pressure Ulcer BWAT Report for Resident #1 documented a Stage II pressure ulcer to the sacral/coccygeal area. It measured 0.5 cm by 0.5 cm by 0.3 cm and was identified as having partial thickness skin loss involving epidermis and/or dermis. The edges were documented as well-defined, not attached to wound base with no undermining. Treatment was documented as, "Clean area [with] NS [Normal Saline], apply foam to open area, skin prep around peri wound. Apply Tegaderm over foam. [Change] daily." There was no further documentation about this pressure ulcer on the BWAT report until 8/23/13, 18 days later.</p> <p>A Nursing Home Visit by the Physician for Resident #1, dated 8/6/13, documented in part:</p> <ul style="list-style-type: none"> * "...The staff is now turning her side-to-side and evaluating why she is getting a skin ulcer. The patient herself is not able to give any information. She is severely debilitated...She really is not able to do anything and requires total care....Plan:...At this time, I am going to have them continue with the wound care to the coccyx, I am going to have them switch her to an air bed turn her side-to-side. In addition, I am going to have occupational therapy evaluate and treat her wheelchair positioning as she does have a reclining back wheelchair and I wonder if she is 	F 314			

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

PRINTED: 03/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2014
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHAB - CALDWELL			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
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F 314	<p>Continued From page 28 being placed up and sliding down causing some shear on the coccyx region to start this ulceration."</p> <p>Resident #1's Occupational Therapy Evaluation, dated 8/7/13, documented: * Reason for Referral, "Pt has a pressure ulcer to her buttock/coccyx - w/c cushion assessment;" * Justification for Skilled Services, "Skilled OT to place appropriate air cushion and assess positioning;" * Summary Statement, "...has declined and has been in a high back w/c for head support. W/C is appropriate - however pt has a pressure wound to her coccyx and could benefit from a ROHO air cushion;" * Short Term Goals, "Trial ROHO saddle cushion for improved skin integrity and w/c positioning;" and, * Long Term Goals, "Pt to have ROHO cushion placed in w/c to [assist] in healing the pressure wound to coccyx area."</p> <p>An Occupational Therapy Discharge Summary for Resident #1, dated 8/12/13, documented, "Roho saddle cushion placed in w/c. Positioning is WFL [Within Functional Limits] and air cushion will [decrease] pressure to coccyx area when in w/c to [assist] in healing wound."</p> <p>A Status Change for Resident #1 was provided by OT, dated 8/12/13, which documented, "D/C [discontinue] OT, Keep ROHO cushion in w/c."</p> <p>On 8/23/13 the wound measured 1 cm by 0.6 cm by 0.4 cm and was still identified as having partial thickness skin loss involving epidermis and/or dermis. However, undermining was now identified at less than 2 cm in any area. The BWAT report</p>	F 314			

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

PRINTED: 03/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2014
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F 314	<p>Continued From page 29</p> <p>included an area for Treatment/Evaluation of Effectiveness which documented, "Wound is larger, pink to wound bed [and] surrounding tissue; will notify MD for new tx [treatment]."</p> <p>A Condition Change form for Resident #1, dated 10/2/13, documented, "[Physician's name] in to see and examine res[ident]. Coccyx ulcer debrided, new orders for tx [treatment]."</p> <p>Resident #1's quarterly MDS assessment, dated 10/7/13, documented in part:</p> <ul style="list-style-type: none"> * Severely impaired cognition; * Extensive assistance needed with 2 or more people for bed mobility, transfers and toilet use; * Extensive assistance needed with 1 person for dressing, personal hygiene and bathing; * Walking in room and corridor did not occur; * Total dependent with the assistance of 1 person for locomotion on and off the unit and eating; * Used a wheelchair; and, * One unhealed Stage II (2) pressure ulcer. <p>Weekly Pressure Ulcer BWAT Reports for Resident #1, dated 11/23/13, documented the stage II pressure ulcer had the measurements of 0.0 cm by 0.0 cm and was identified as a healed, resolved wound. The Treatment/Evaluation of Effectiveness documented, "Wound healed. Surrounding skin irritated by Duoderm. Tx D/C'd cont. [Treatment discontinued, continue with] barrier cream q [every] incont[inent] episode." Note: On 3/13/14 at 3:47 p.m., the DON stated the wound was not healed, just closed.</p> <p>A Condition Change Form for Resident #1, dated 11/30/13, documented, "Coccyx wound with thick white tissue. Discussed with MD possible debridement. MD explained that she debrided this</p>	F 314		

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

PRINTED: 03/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2014
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F 314	<p>Continued From page 30 wound once. Recommended (sic) to keep wound dry. Dry coccyx with cares then apply Calzime barrier cream."</p> <p>A Post-Event Assessment with an attached Condition Change Form, dated 12/7/13, documented, "Open area noted to coccyx with weekly skin assessment. Drsg [dressing] of comfeel plus placed. Wound 2.5 cm from 12 o'clock to 6 o'clock. Width from 3 o'clock to 9 o'clock. [No] tunneling, [no] odor, [no] warmth, surrounding skin intact, [no] edema to surrounding skin. Scant drg [drainage] of serosanguinous drg [drainage]."</p> <p>A Post-Event Action sheet had an attached Condition Change Form, dated 12/9/13, which documented, "Hx [history] of dementia has an open area on coccyx that has reopened more. [Physician's name] had changed the tx a couple weeks ago [.] New drsg [dressing] orders monitor until resolved. Cont[inue] air bed cont[inue] Roho cushion [with] RNA checking daily for proper inflation."</p> <p>Change of Condition Forms for Resident #1 documented: * 12/20/13 - "Wound not improving [with] current treatment to coccyx, [changed] orders for dressing;" and, * 1/12/14 - "Coccyx wound [increased] maceration with measurements [greater than] 1 cm larger than last measurement. Current tx [treatment] of polymem Silver with tegaderm [and] skin prep. Please advise of recommended [changes]. Cont[inue] on air mattress pressure setting 5 [and] turned q [every] 2 [hours] PRN [as needed]."</p>	F 314			

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

PRINTED: 03/25/2014
FORM APPROVED
OMB NO. 0938-0391

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F 314	<p>Continued From page 31</p> <p>A Resident Progress Notes form for Resident #1, dated 1/13/14, documented, "RAR [Resident At Risk]: Has a wound on her coccyx that despite multiple interventions has declined [.] [Physician's name] is going to review tomorrow and will be setting up appt [appointment with] wound clinic and will have dietician review."</p> <p>A Change of Condition form for Resident #1, dated 1/14/14, documented, "[Physician's name] in [and] examined coccyx wound. She states wound is clean, no rolled edges, [no] infection possible reasons for decline this week 1[.] too wet 2[.] wrong dressing used 3[.] drsg [dressing] not changed frequently enough. She discussed her assessment [with Resident's name] husband. At this time will D/C appt [with] wound clinic and [increase] frequency of dressing change."</p> <p>A Weekly Pressure Ulcer BWAT Report for Resident #1 documented in part: * 1/31/14 - Wound measured 1.5 cm by 0.4 cm by 0.5 cm by 0.5 cm; and, * 2/23/14 - Wound measured 1.7 cm by 0.6 cm by 0.2 cm by 0.5 cm. The Treatment/Evaluation of Effectiveness on the report documented, "Wound is deteriorating D/T [due to] dressing is not staying in place [and] contaminated by bowel [and] urine. Bed is moist beety red [and] grainy, edges of wound pale. Will notify MD for tx [treatment change]."</p> <p>Resident #1's Physician recapitulation orders for 2/26/14 through 3/31/14 documented, "Resident last up, first down. Turn side to side...Cut to fit Alginate AG to wound bed, apply skin prep to periwound and cover with duoderm, change daily and as needed...Check placement of dressing every shift..."</p>	F 314		

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

PRINTED: 03/25/2014
FORM APPROVED
OMB NO. 0938-0391

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F 314	<p>Continued From page 32</p> <p>Note: the intervention of last up first down was not added to the care plan until 2/14/14, 6 months after the wound developed.</p> <p>On 3/13/14 at 9:06 a.m., the Occupational Therapist was interviewed about Resident #1. She said the resident was seen in July 2013 for leaning back in a normal wheelchair and the resident's head and neck needed support. The resident was then placed in a high back tilt back wheelchair. The OT did not recall working with positioning at that time related to the resident sliding down in the wheelchair. The OT said she put a saddle cushion in the high back wheelchair which would have decreased any sliding down. Resident #1 was seen again in August for the Roho cushion after there had been skin breakdown. The OT said she switched from the saddle cushion to the Roho saddle cushion and had not been a part of any discussion related to the resident sliding down in the wheelchair. She added that positioning was not a concern in August, it was for wound healing.</p> <p>On 3/13/14 at 9:50 a.m., the DON and DDCO were interviewed about Resident #1's pressure ulcer. The DDCO referred to the resident's body tone as a contributing factor the the resident sliding down in the wheelchair and referred to the MD note from 8/6/13. When asked why there was no documented evidence in the resident's medical record discussing lack of tone or sliding down in the wheelchair, the DDCO saris she would review nurses notes.</p> <p>On 3/13/14 at 10:12 a.m., the DDCO provided a copy of the MD note from 8/6/13 and said there was no documentation in the nurses notes about</p>	F 314			

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

PRINTED: 03/25/2014
FORM APPROVED
OMB NO. 0938-0391

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F 314	<p>Continued From page 33 the resident sliding down in the wheelchair.</p> <p>On 3/13/14 at 4:20 p.m., the DON was asked why Resident #1's pressure ulcer was not measured for 18 days he stated, "My guess is that they just didn't do it" and said he would look in the medical records. However, no documentation was provided.</p> <p>2. Resident #3 was admitted to the facility with multiple diagnoses including dementia with behavior disturbances, paralysis agitans, and secondary Parkinsonism.</p> <p>The resident's 3/3/14 annual MDS coded severe cognitive impairment, totally dependent on staff for ADLs, at risk for developing Pressure Ulcers (PUs), no unhealed PUs, and pressure relieving device for chair and bed. The resident's 3/4/14 Care Area Assessment documented the Pressure Ulcer care area triggered and was care planned.</p> <p>The resident's 3/5/14 Care Plan (CP) identified, in part: - Problem 12/10/2008, Self-Care Deficit: Toileting-Incontinence. Two of the 4 problem approaches were: "Provide incontinent care with each change...Check and change AM/PM before and after meals and rest periods and prn. Pericare after each incontinent episode." - Problem 12/10/2008, Physical Mobility, impaired. Three of the 6 problem approaches were: "Turn & reposition when in bed. Avoid skin on skin contact. Use pillows as needed...Bed mobility with extensive assist of 2...Use drawsheet in w/c to assist with positioning."</p>	F 314			

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

PRINTED: 03/25/2014
FORM APPROVED
OMB NO. 0938-0391

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F 314	<p>Continued From page 34</p> <p>- Problem 12/10/2008, Skin/Tissue Integrity impaired: Potential. The problem goal was, "No avoidable skin impairment next quarter." Problem approaches included, turn and reposition when in bed. Avoid skin on skin contact. Use pillows as needed and report any red or open areas.</p> <p>The resident's 3/5/14 CP also contained two handwritten "CP Update" forms as follows:</p> <p>- 3/4/14, Impaired Skin Integrity. Approaches: "Cleanse area on lt buttock [with] ns [on left buttock with normal saline] or wound cleanser. Use skin prep on surrounding tissue: cover [with] duoderm [change] q day [change every day]."</p> <p>- 3/5/14, Impaired Skin Integrity. Approaches: "1. Cont [continue] to monitor & tx [and treat] until resolved. 2. When in bed leave open to air, turn side to side. 3. Use lighter turn sheet (bedsheet) for turning/positioning. 4. Use Xenaderm on abraded {sic} [abraded] area [after] each inc [incontinent] episode."</p> <p>On 3/4/14 at 2000 (8:00 p.m.), the "Resident Progress Notes" documented, "During cares aides found an abraided {sic} area on res L [resident's left] beefy area of buttock. Area is 1 x .7 [1.0 by .70 centimeters (cm) with no] drainage. Interventions in place include an airbed, Broda chair [with] Roho cushin {sic} [cushion]." LN #4 signed the entry.</p> <p>On 3/4/14 the resident's "Physician Telephone Orders (T.O.) documented, in part, "1. Cleanse area on [left] buttock [with] ns [normal saline] or wound cleanser, use skin prep [preparation] on surrounding tissue, cover over [with] duoderm."</p> <p>On 3/4/14 the resident's "Weekly Non-Pressure</p>	F 314		

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

PRINTED: 03/25/2014
FORM APPROVED
OMB NO. 0938-0391

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F 314	<p>Continued From page 35</p> <p>Skin Condition Report" form documented, "Size in cm (L x W x D) [length by width by depth] 1.0 x 0.7; Color, red, moist, grainy, optimal granulation; Exudate type, none; No odor; Continue treatment."</p> <p>On 3/5/14 the "Resident Progress Notes" documented, in part, "...Upon review the resident is [with] heavy incontinent [with] frequent attend changes, upon turning [with] drawsheet an abrasion was sustained to [left] buttock area, is in thick meaty area of buttock. Plan...Use lighter turn sheet (bedsheet) for turning/positioning..." The DON signed the entry.</p> <p>On 3/5/14 the resident's T.O. documented, in part, "1. Skin prep around abraided {sic} area on [left] buttock q [every] day. 2. Xenaderm to abraided {sic} area [after] each inc. [incontinent] episode until resolved. 3. Xenaderm PRN bid [as needed two times a day] to abraided {sic} area [after] resolution T.O. [physician's name]." The T.O. was signed by the resident's physician on 3/6/14.</p> <p>On 3/8/14 the "Resident Weekly Skin Check Sheet" documented, in part, "...open sore to [left] buttock..."</p> <p>Note: Federal guidance at F314 specified, in part, "Pressure Ulcer - A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s). Although friction & shear are not primary causes of pressure ulcers, friction & shear are important contributing factors to the development of pressure ulcers...Friction/Shearing...Friction is the mechanical force exerted on skin that is dragged across any surface..."</p>	F 314			

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

PRINTED: 03/25/2014
FORM APPROVED
OMB NO. 0938-0391

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F 314	<p>Continued From page 36</p> <p>On 3/11/14 at 1:40 p.m., a surveyor observed the resident's buttocks. There was an open area on the left buttock with red edges, no oozing, and the area was dry. The size was approximately 1.0 cm in length by 0.5 in width.</p> <p>On 3/14/14 at 9:05 a.m., the surveyor discussed the resident's left buttock abrasion with the DON. The DON stated, "The abrasion occurred when staff repositioned the resident. We had a Wound Nurse come in on 3/5/14 and evaluate the compromised area." The surveyor then referred the DON to the "Resident Progress Notes" that did not include any entries from nursing staff of a Wound Nurse attending to the resident. The surveyor asked the DON if the Wound Nurse wrote a progress note and if a progress note was written would it be included in the clinical record? The DON indicated a Progress Note was not written by the "Wound Nurse." The surveyor asked the DON how the determination was made for the 3/5/14 entry, "the resident is with heavy incontinent and frequent attend changes." The DON said when he investigated the abrasion, the CNAs said the resident had heavier than usual incontinence. The surveyor informed the DON of the concern the resident sustained a left buttock abrasion and the abrasion occurred due to pressure.</p> <p>The resident's 3/14 Bladder/Bowel Record was reviewed. On 3/4/14, evening shift, the resident had one medium bowel incontinent and two bladder incontinent episodes.</p> <p>On 3/14/14 at 9:20 a.m., the DON provided the surveyor with a "Timeline of Events" that documented in part, "Not in record - A wound</p>	F 314		

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

PRINTED: 03/25/2014
FORM APPROVED
OMB NO. 0938-0391

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F 314	Continued From page 37 nurse from [local facility's name] came to assess area with DNS...The determination was that it was not located on her coccyx, or near her isheal tuberosity. The areas was not mirrored on her buttocks and it was of irregular in shape. The area is fragile and the abrasion was determined to be from the thicker draw sheet that was used..." Resident #3 was totally dependent on staff for all ADLs. While staff were turning/repositioning the resident with a drawsheet, the use of the drawsheet caused an abrasion to the resident's left buttock. On 3/14/14 at 1:00 p.m., the Administrator was informed of the concern.	F 314			
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format.	F 356	F356 POSTED NURSE STAFFING INFORMATION 1. The form was changed on the day the surveyors brought the issue to the attention of the ED. 2. All residents who want to know the numbers of staff on duty per shift by discipline have the potential to be affected. 3. The Kindred policy and procedure states the nurse staffing shall be posted each day per federal guidelines. The form previously used did not differentiate between RNs and LPNs, and did not list facility census each day. These forms have been discarded and the new forms are being used. The staffing coordinator has been educated to use of the appropriate tool with details.	4/14/14	

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

PRINTED: 03/25/2014
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F 356	Continued From page 38 o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and Administrator interview, it was determined the facility failed to ensure the posted Nurse Staffing contained all required information. Findings included: On 3/10/14 at 9:37 a.m., the Administrator and the surveyor reviewed the Nurse Staffing posted in the 200 hallway. The posted Nurse Staffing identified by day, evening, and night shift the numbers of "licensed and unlicensed staff and the date." The staffing did not include the resident census or the total number and the actual hours worked by registered nurses (RNs), licensed practical nurses (LPNs) and certified nurse aides (CNAs). The Administrator said the nurse posting will be updated to include census and the hours worked by RNs, LPNs, and CNAs.	F 356	4. The ED and/or designee will monitor starting the week of April 14 the completion and accuracy of the posted nurse staffing forms on a weekly basis. The results of this monitoring will be documented on the PI audit tool. Any concerns will be addressed immediately and reported to the PI Committee. The PI Committee may adjust the frequency of monitoring after 12 weeks, as it deems appropriate.		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2014
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHAB - CALDWELL			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 39</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure food was stored under sanitary conditions in the walk-in freezer. This had the potential to affect 13 of 13 (#s 1-13) sampled residents and any resident who requested apple pie or pumpkin pie. This practice created the potential to expose residents to disease causing pathogens. Findings included:</p> <p>On 3/10/14, the Dietary Manager (DM) accompanied the surveyors during the initial tour of the facility's kitchen. At 8:30 a.m., a build-up of what appeared to be ice was observed under the condenser unit. The ice was in direct contact with aluminum foil loosely wrapped over a 9 inch apple pie. Review of the apple pie provided evidence some portions had been served and there were some portions of apple pie still in the pie pan. There was also a frozen pumpkin pie, in the original packaging, with a build-up of ice on the cardboard container.</p> <p>The build-up of ice on the foil, wrapped around the apple pie at the highest point, was approximately 2.5 inches in height and</p>	F 371	<p>F371 FOOD PROCURE, STORE/PREPARE/SERVE IN A SANITARY MANNER</p> <ol style="list-style-type: none"> 1. The food which had ice build up on the outside of the packaging was discarded immediately. There was never a time when the ice came in direct contact with food stored in the freezer. 2. All residents have the potential to be affected by food which comes into contact with condenser ice. 3. A service technician was called regarding the ice build up. In the meantime, pans were placed directly under the refrigeration unit to capture any ice which could form under the unit. The service technician indicated there was a leak in the roof above the condenser unit, which increased the humidity in the condenser and caused excessive buildup of water during a defrost cycle. Once the outside air temperature exceeds 70 degrees F, he will return and reseal the area above the condenser. In the interim, pans will remain in the freezer to catch any ice build up below the cooling unit. These will be cleaned daily to prevent any ice from coming into contact with packages containing food. 	4/14/14	

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

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F 371	Continued From page 40 approximately 4-5 inches in length. The build-up of ice on the pumpkin pie container was approximately 1.5 inches at the highest point and approximately 4-5 inches in length. On 3/10/14 at 8:32 a.m., the DM stated, "That should not be like that. I will have maintenance look at the unit." The DM immediately removed the potentially comprised pies from the walk-in freezer. On 3/14/14 at 1:00 p.m., the Administrator was informed of the observation.	F 371	4. The Food Service Supervisor and/or designee will evaluate the replacement of the pans starting the week of April 14 no less than three times per week. Once the roof has been repaired, monitoring will continue for the next 2 weeks, then monthly thereafter. The results of this monitoring will be documented on the PI audit tool. Any concerns will be addressed immediately and reported to the PI Committee. The PI Committee may adjust the frequency of monitoring after 12 weeks, as it deems appropriate.		
F 458 SS=D	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, it was determined the facility failed to ensure rooms with multiple residents had at least 80 square feet of living space per resident. This affected 3 of 31 resident rooms (#s 111, 112 and 114) that did not meet the minimum requirement of 80 square feet per resident. This practice created the potential for residents to experience a loss of well-being. Findings included: - 2 residents were in room 111, which had 78.6 square feet per resident. - 2 residents was in room 112, which had 79	F 458	F458 BEDROOMS AT LEAST 80 SQUARE FEET PER RESIDENT Kindred Nursing and Rehabilitation-Caldwell requests a continuation of the waiver of this requirement. The residents in the affected rooms have not indicated, through verbal complaints or an exacerbation in negative well-being, due to the rooms being between 1 and 3 square feet less than 80 square feet per resident.	4/14/14	

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F 458	Continued From page 41 square feet per resident. - 2 residents were in room 114, which had 79.5 square feet per resident. On 3/13/14 at approximately 2:15 p.m., rooms 111, 112, and 114 were observed to meet the needs of the current residents in those rooms. The furniture in the rooms was arranged in a manner that provided for ease of access to the beds and closets. On 3/13/14 at approximately 2:30 p.m., Random Resident #s 21, 23, 24, 25, & 26 were interviewed about the size of their rooms. None of the residents expressed dissatisfaction with the size of their rooms. The residents' responses ranged from "nice room" to "room is okay." The facility had a room size requirement waiver for rooms 111, 112 and 114 which was granted on 2/15/13. This waiver was in effect until the next on-site survey. On 3/14/14 at 1:00 p.m., the Administrator and the District Director of Clinical Operations stated the facility was again requesting a waiver for the room size requirement.	F 458			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient	F 514	F514 RESIDENT RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 4. The physician recapitulation sheets, medication and treatment administration records were accurate for resident # 3, 6, & 9. The change dates were noted on the actual order, but not transcribed to the physician recapitulation sheets or medication/treatment administration record. No changes were made to resident #3, 6, & 9 medical records for this issue, as date/initials cannot be added retroactively.	4/14/14	

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F 514	<p>Continued From page 42</p> <p>information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices to ensure records were complete and accurate. This was true for 3 of 15 (#s 3, 6, & 9) sampled residents. This deficient practice increased the risk for medical decisions to be based on incomplete or inaccurate information and increased the risk for complications due to inappropriate care or interventions. Findings included:</p> <p>1. Resident #6 was admitted to the facility on 5/3/12 and readmitted on 12/24/13 with multiple diagnoses which included right heel decubitus ulcer, dementia and diabetes.</p> <p>February 2014 Physician recapitulation orders documented, "EASY AIR BED SETTING 5, CHECK EVERY SHIFT...AVEENO TO COCCYX SPLIT Topical THREE TIMES A DAY AND PRN AFTER EACH INCONTINENT EPISODE." The far left column on the recapitulation orders was entitled D/C (discontinue) Date. The D/C Date for each aforementioned order had a written, "D/C" documented in the column. However, a date of the discontinued order was not documented, nor were there initials documenting who wrote the "D/C" in the D/C Date column.</p>	F 514	<p>2. All resident records had similar transcription practices. No changes were made to the medical records retroactively. As noted below, education was provided to staff for documentation going forward. Staff monitors each other between shifts to validate correct order notation with date and initials. Before the end of the shift, orders without dates or initials are corrected by the nurse who transcribed the order.</p> <p>3. Licensed Nurse Staff will be educated by the DNS and/or designee no later than April 11, 2014 regarding complete and accurate medical records, to include but not limited to physician order transcription process to include date of order or change and staff initials. Staff monitors each other between shifts to validate correct order notation with date and initials. DNS reviews all physician recapitulations each month after updates to validate change dates and staff initials.</p> <p>4. The Medical Records Clerk and/or designee will review physician order transcription for dates and initials starting the week of April 14 no less than three records per week for 3 months. The results of this monitoring will be documented on the PI audit tool. Any concerns will be addressed immediately and reported to the PI Committee. The PI Committee may adjust the frequency of monitoring after 12 weeks, as it deems appropriate.</p>		

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F 514	<p>Continued From page 43</p> <p>On 3/12/14 at 1:55 p.m., the DDCO was interviewed about the lack of dates and initials on the Physician recapitulation orders for Resident #6. When asked what the process was for orders discontinued from the recapitulation orders, the DDCO said they would verify with telephone fax orders or written Physician orders. The DDCO was informed of the orders discontinued on Resident #6's Physician recapitulation orders and was asked if she would expect to see a date with initials. The DDCO did not provide a clear response, but said she would look into it. However, no further information or documentation was provided.</p> <p>2. Resident #3 was admitted to the facility with multiple diagnoses including dementia.</p> <p>The resident's 3/14 Physician's Orders (recapitulation orders) contained, in part, the following handwritten entries.</p> <p>* Page 1, in the discontinue column, "2/12/14." The 2/12/14 entry was not initialed to indicate who made the entry.</p> <p>* Page 5, in the discontinue column, "3/3/14." The 3/3/14 entry was not initialed to indicate who made the entry.</p> <p>The resident's 3/14 MAR contained, in part, the following handwritten entries. The entries did not include the order dates and were not initialed or dated to indicate when the entries were made on the MAR.</p> <p>* Page 2, In the far left hand column (order column), was a handwritten entry, "Prllosec Sprinkle 20 mg po q 8am [20 milligrams by mouth every day at 8:00 a.m.]."</p> <p>* Page 4, In the far left hand column (order column) there were four separate handwritten</p>	F 514		

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F 514	<p>Continued From page 44</p> <p>entries, "Total hours slept; Depression monitor 1=depressed 2=baseline 3=manic; Xenaderm to abraided {sic} area [after] each inc [incontinent] episode until resolved; and Xenaderm pm bid [as needed two times a day] to abraided {sic} area [after] resolution."</p> <p>3. Resident #9 was admitted to the facility with multiple diagnoses including delirium.</p> <p>The resident's 3/14 Treatment Record contained, on Page 1, an order dated 12/22/13, change dressing to left outer wrist every day and pm until resolved. To the reader's right of the 12/22/13 order, there was a handwritten entry, "resolved." The entry was not dated or initialed to indicate when the resolved entry were made on the Treatment Record.</p> <p>On 3/14/14 at 1:00 p.m., the Administrator and the DDCO were informed the surveyors had concerns with accuracy and completeness of clinical records.</p>	F 514			

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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 State licensure survey and complaint investigation of your facility. The surveyors conducting the survey were: Karen Marshall MS RD LD Team Coordinator Rebecca Thomas, RN Lauren Hoard, RN BSN	C 000	RECEIVED MAY - 8 2014 FACILITY STANDARDS	
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 relates to privacy during medical treatment. Please refer to F241 as it relates to dignity and respect during dining and during transfers.	C 125	C125 Treated with Respect/Dignity Please see the POC for the 2567 as it relates to F241 and F164	4/14/14
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards	C 325	C325 Food Sanitation Please see the POC for the 2567 as it relates to F371	4/14/14

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kim L. Holley</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>5/7/2014</i>
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C 325	Continued From page 1 for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Please refer to F371 as it related to sanitary conditions in the kitchen.	C 325		
C 405	02.120,05,e Meets Room Dimension Requirements e. Patient/resident rooms shall be of sufficient size to allow not less than eighty (80) square feet of usable floor space per patient/resident in multiple-bed rooms. Private rooms shall have not less than one hundred (100) square feet of usable floor space. This Rule is not met as evidenced by: Please refer to F458 as it related to the room size of rooms 111, 112, & 114.	C 405	C405 Room Dimension Requirements Please see the Request for Waiver on the 2567 as it relates to F458	4/14/14
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 staff interviews, it was determined the facility failed to maintain the minimum number of tubs or showers for licensed beds. This affected 13 of 13 (#s 1-13) sampled residents, 11 of 11 (#s 16 - 26) random residents,	C 422	C422 Capacity Requirements for Toilets/Bath Areas This facility requests a continuation of the waiver for this requirement. There have not been any instances whereby residents failed to receive proper bathing with the currently available tubs and showers. We have three portable bathtubs available if necessary as well.	4/14/14

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C 422	Continued From page 2 and had the potential to affect all residents who resided in the facility. Findings included: The facility was licensed for 71 beds. At the beginning of the survey process, 61 residents resided in the facility. State guidance at C422 indicated, in part, "...there shall be at least one (1) tub or shower for every twelve (12) licensed beds..." Seventy-one licensed bed divided by 12 licensed beds equaled 5.916 or 6 tubs or showers. During the "General Observations of the Facility" on 3/13/14 at 2:00 p.m., the Maintenance Director accompanied the surveyor. The East tub room had one tub, the Spa room had one shower, and the West Bath had one shower. The number of tubs or showers in the facility totaled 3. The MD stated, "There are no other bathing facilities. We have portable showers we can connect to the faucets of sinks." The MD showed the surveyor an attachment on the faucet of a sink and then lead the surveyor to the place where 3 portable shower units were stored. The MD stated, "All faucets have the same attachment that I just showed you to connect one of these portable shower units." On 3/14/14 at 1:00 p.m., the Administrator and the District Director of Clinical Operations both said the facility was requesting a waiver of the tub and shower requirement.	C 422		
C 440	02.120,12 HEATING 12. Heating. A heating system shall be provided for the facility that is capable of maintaining a temperature	C 440	C440 Heating Please see the POC for the 2567 as it relates to F257.	3/14/14

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C 440	Continued From page 3 of seventy-five degrees (75F) to eighty degrees (80F) Fahrenheit in all weather conditions. This Rule is not met as evidenced by: Please refer to F257 as it related to comfortable temperatures in the building.	C 440		
C 782	02.200,03,a,iv Reviewed and Revised 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 refer to F-280 as it relates to Comprehensive Care Plans.	C 782	C782 Reviewed and Revised Care Plans Please see the POC for the 2567 as it relates to F280	4/14/14
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F309 as it related to not developing a resident care plan for comfort measures. Please refer to F-309 as it relates to quality of care.	C 784	C784 Resident Needs Identified Please see the POC for the 2567 as it relates to F309	4/14/14
C 789	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2)	C 789	C789 Prevention of Decubitus Please see the POC for the 2567 as it relates to F314	4/14/14

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C 789	Continued From page 4 hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 as it related to pressure ulcers.	C 789		
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Refer to F514 as it relates to complete and accurate medical records.	C 881	C881 Individual Medical Record Please see the POC for the 2567 as it relates to F514	4/14/14



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
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April 9, 2014

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

Provider #: 135014

Dear Mr. Holloway:

On **March 14, 2014**, a Complaint Investigation survey was conducted at Kindred Nursing & Rehabilitation - Caldwell. Karen Marshall, R.D., Becky Thomas, R.N. and Lauren Hoard, R.N. conducted the complaint investigation. This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey.

Four of the identified residents were observed during the survey process for quality of life, quality of care, room and daily life reviews, drug therapies, minimum data set and care area assessments.

The clinical records of four of the identified residents and the closed record of another identified resident were reviewed.

Interviews were conducted with the following:

- Two of the identified residents;
- A family member of one identified resident;
- Certified Nurse Aide (CNA) who provided care to one of the identified residents;
- Four Licensed Nurses;
- Director of Nursing;
- District Director of Clinical Operations;
- Supply Clerk;
- Two Licensed Social Workers; and

Rick L. Holloway, Administrator
April 9, 2014
Page 2 of 7

- A physician of one of the identified residents.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006178

ALLEGATION #1:

The complainant stated an identified resident acquired a stage II decubitus pressure ulcer while in the facility. The wound was measured on August 5, 2013, but not measured again until August 23, 2013. On August 23, 2013, the wound had significantly deteriorated, nearly tripled and begun to tunnel into the resident's skin.

FINDINGS:

The identified resident developed a stage II decubitus pressure ulcer while in the facility. The wound was not measured for eighteen days from August 5, 2013 to August 23, 2013. The wound did increase in size and undermining of less than two centimeters.

The facility was cited at F314 for non-compliance.

CONCLUSIONS:

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

ALLEGATION #2:

The complainant stated there are skin issues in the facility, and an identified resident developed pressure sores to the feet.

FINDINGS:

The identified resident's clinical record was reviewed.

The identified resident was admitted to the facility on May 3, 2012, and readmitted on December 24, 2013, with a history of skin breakdown.

The DoN and District Director of Clinical Operations (DDCO) were interviewed about the identified resident. They both said the identified resident developed callouses from the diabetic shoes; therefore, the facility took away the shoes and Prevalon boots were to be worn at all times. The DoN and DDCO provided documented evidence, which included the working care plan before, during and after the callous developed, Flow Sheet Records, Treatment Records, an MD

Rick L. Holloway, Administrator
April 9, 2014
Page 3 of 7

note and the receipt for new diabetic shoes.

The Minimum Data Set assessments before and after the development of callouses were reviewed and confirmed the identified resident did not ambulate and required use of a wheelchair for locomotion, and the identified resident did not have healed or unhealed pressure ulcers.

The care plan was reviewed and confirmed interventions of prevention and treatment were in place prior to and after the callous identification. In addition, the care plan confirmed the wheelchair was the identified resident's primary mode of transportation.

Review of treatment records showed interventions were verified as completed for skin breakdown prevention, which included checking the heels daily, in addition to monitoring the heels every shift for two weeks, after the identified resident received the new diabetic insoles.

Resident Weekly Skin Check Sheets were reviewed and confirmed skin assessments were being performed weekly.

A receipt for new diabetic shoe and special insoles from a local foot and shoe center provided evidence that the identified resident received new shoes and insoles prior to the callous development.

A nursing home visit by the physician on August 8, 2013, documented the identified resident had developed areas of friction on the heels from the new diabetic shoe insoles. Therefore, the shoes were taken away, and the identified resident wore Prevalon boots bilaterally at all times. When the identified resident was non-compliant with the Prevalon boots, she received education from the physician and nursing staff and was then agreeable to wear the boots.

Observations were made of the identified resident that verified interventions were in place to prevent skin breakdown, which were implemented consistently.

In summary, based on observations, records reviewed and interviews with facility staff, it could not be determined that the callous formation on the identified resident was due to facility non-compliance.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated an identified resident obtained multiple pressure sores while residing in the facility.

Rick L. Holloway, Administrator
April 9, 2014
Page 4 of 7

The facility quickly discharged the resident after the pressure sores developed to avoid the state survey team seeing the resident with the pressure sores.

FINDINGS:

This allegation was previously investigated on March 3, 2013. The survey team, at that time, determined the allegation to be not substantiated due to lack of sufficient evidence. This allegation was not reopened.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated an identified resident requested different adult incontinence products because the current incontinent product caused the resident's skin to breakdown.

The request was refused by an identified employee who said, the Administrator said, the requested adult incontinent product was too expensive to purchase for the resident.

FINDINGS:

The identified resident was interviewed regarding incontinent products. The resident stated she was allergic to the incontinent product and had some skin irritation. The facility offered and provided a different incontinent product, and she was not having any problems with the use of the new incontinent product.

The resident expressed no concerns to the surveyor about the way the request for the different incontinent product was handled. The resident said she did not have any concerns or problems with skin breakdown related to the use of incontinent products.

Review of the resident's clinical record did not provide evidence that the resident had compromised skin due to the use of an incontinent product.

The identified supply clerk was interviewed and said there was a request made by the resident for a different incontinent product. The supply clerk said the resident requested a size smaller than the size she was using. When asked if she remembered a time when someone said it was too expensive, the supply clerk said, no, I have been way over budget for incontinent products for a while.

A Certified Nurse Aide (CNA) who provided personal cares for the resident was interviewed and

Rick L. Holloway, Administrator
April 9, 2014
Page 5 of 7

said; she remembered the facility had to order a different incontinent product for the resident. When the surveyor asked the CNA how long of a time elapsed after the resident requested a different incontinent product, the CNA said a couple of days at the most.

The survey team determined the facility was in compliance with Federal guidelines.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated an identified resident had a wound that significantly deteriorated since the resident was admitted to the facility.

The resident was sent to a wound clinic, where the clinic ordered Unna boots to the resident's feet bilaterally.

The Director of Nursing (DoN) told three identified nurses the order of sequence for the Unna boot was the cotton wrap then the medicated wrap followed by the Kerlex.

One of the identified nurses, who attended an in-service at the wound clinic, tried to correct the DoN that the order was actually; the medicated wrap, then the cotton wrap, then the Kerlex. The DoN refused to listen and changed the days the dressing was changed to ensure that the dressing was changed incorrectly.

The resident returned to the wound clinic. The clinic ordered that the resident must come to the clinic for dressing changes to ensure that the dressing was changed correctly and the staff required further education regarding the dressing changes, which would have been changed correctly had the DoN not insisted that the dressing be placed backwards.

During this time that the DoN insisted the dressing be changed vice versa, the resident's wound deteriorated.

FINDINGS:

The identified resident leg wounds were seen by a local wound clinic. Unna boots were ordered for the resident.

A wound clinic progress note documented the Unna boots were placed on the resident incorrectly.

Rick L. Holloway, Administrator
April 9, 2014
Page 6 of 7

The facility was cited at F309 for non-compliance.

CONCLUSIONS:

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

ALLEGATION #6:

The complainant stated a resident whose possible first name was provided, but no last name was provided was his own guardian and wanted to leave but was not allowed to.

Another identified resident who was her own guardian often expressed a desire to leave and felt like she was being kept hostage and not permitted to leave despite being her own guardian.

FINDINGS:

The survey team reviewed the resident roster to identify the resident whose possible first name was provided but no last name was provided. The survey team could not determine the identify of the resident whose last name was not provided.

Review of the facility's Grievances did not provide evidence the identified resident or any other residents complained the facility would not allow discharge and held the residents against their will.

The closed record of the identified resident whose name was provided was reviewed. The resident was admitted to the facility on March 20, 2013, and discharged from the facility to another facility in the local area on March 6, 2014.

Review of the resident's closed record did not provide evidence the resident complained to nursing staff or to social services that she was being held against her will. The record documented appropriate discharge planning.

The identified resident's physician was interviewed. The physician said the resident wanted to pursue more art. When asked, the physician reported the resident did not tell the physician she felt she was being held hostage and not permitted to leave the facility. The physician said, "We strategized her goals with her and found a different facility for her."

One of two licensed social workers (LSW) said, when the resident was admitted to the facility in March 2013, the resident had cares and needs that required nursing care. However, the resident's condition improved, and the resident expressed to the LSW the desire to live closer to her mother, in a facility where the resident could pursue her artistic talents, interests and dreams. The LSW researched the local area and provided the resident's mother and the resident with the

Rick L. Holloway, Administrator
April 9, 2014
Page 7 of 7

name of two different facilities in the local area that were located closer to where the resident's mother lived and that could provide the environment for the resident to pursue her artistic talents, interests and dreams. The mother visited the different facilities and chose the facility where the resident could pursue her dreams.

The LSW said, after the resident moved to the different facility, she personally visited with the resident, and the resident said she was much happier in the new facility.

The survey team determined the facility was in compliance with Federal guidelines.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,



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

LT/dmj