



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 1635**

May 20, 2014

Gerald L. Bosen, Administrator  
Kindred Nursing & Rehabilitation - Weiser  
331 East Park Street  
Weiser, ID 83672-2053

Provider #: 135010

Dear Mr. Bosen:

On **May 9, 2014**, a Recertification and State Licensure survey was conducted at Kindred Nursing & Rehabilitation - Weiser by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies 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) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both the Form

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CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 2, 2014**. Failure to submit an acceptable PoC by **June 2, 2014**, may result in the imposition of civil monetary penalties by **June 23, 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 does 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 (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

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- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **June 13, 2014 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **June 13, 2014**. A change in the seriousness of the deficiencies on **June 13, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 13, 2014** includes the following:

Denial of payment for new admissions effective **August 9, 2014**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **November 9, 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 Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **May 9, 2014** and continue until substantial

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compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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

- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)

[2001-10 IDR Request Form](#)

This request must be received by **June 2, 2014**. If your request for informal dispute resolution is received after **June 2, 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, comments or concerns, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,



LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor  
Long Term Care

LKK/dmj  
Enclosures

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

PRINTED: 05/19/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/09/2014
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NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHABILITATION - WEISER	STREET ADDRESS, CITY, STATE, ZIP CODE 331 EAST PARK STREET WEISER, ID 83672
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Sherri Case, BSW, LSW, QIPD, Team Coordinator Jana Duncan, RN, MSN</p> <p>The survey team entered the facility on May 5, 2014 and exited on May 9, 2014.</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CNA = Certified Nurse Aide DNS = Director of Nursing Services LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment POA = Power of Attorney PRN = As Needed</p>	F 000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.</i></p>	
F 309 SS=D	<p><b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b></p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was</p>	F 309	<p><b>F-309 Specific Residents</b></p> <p>Resident #3 care plan is updated to include non-pharmacological sleep hygiene – warm blanket, dark room (turn off lamp), and reassurance wife will return tomorrow. His care plan and behavior monitor is also updated to address agitation exhibited through various delusions of lost items, people taking his things, and over stimulation.</p> <p><b>Other Residents</b></p> <p>The clinical management team reviewed residents with hypnotics and adjusted care plans to include specific non-pharmacologic sleep hygiene interventions.</p>	

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FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Gerald Bose</i>	TITLE Executive Director	(X6) DATE 5/30/14
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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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NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHABILITATION - WEISER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</b>	
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F 309	<p>Continued From page 1</p> <p>determined the facility failed to try less restrictive interventions related to sleep and ensure consistent monitoring of delusions and for 1 of 4 sample residents (#3) with dementia. This placed the resident at risk for a functional decline. Findings included:</p> <p>Resident #3 was admitted to the facility on 9/1/10 and readmitted on 3/22/12 with diagnoses which included senile dementia and delusional disorder.</p> <p>a. Resident #3's 5/14 recapitulation Physician's Orders included an order for Risperdal (antipsychotic) 0.5 mg in the evening for delusional disorder with a start date of 3/18/14.</p> <p>The resident's 4/30/14 Care Plan for impaired thought process documented "...delusions as evidenced by overtly stressed by (sic) perceives sabotage of court reported occupation related to over stimulation which results in aggression during care contact."</p> <p>The interventions were to redirect, two people provide cares, leave alone if safe and return later, toilet, one to one, offer food, activity, reassurance and to offer to sit in recliner.</p> <p>The Monthly Behavior Monitoring Flowsheet (MBMF) for 3/2014 included "Delusions (need to go to work/Drive the car)." The MBMF documented 0 days with delusions on the day shift, 7 days (10 incidents) on the evening shift and 1 day (3 incidents) on the night shift.</p> <p>The resident's medical record included an MBMF for 4/1/14 which was discontinued on 4/4/14. The target behavior was "delusions" and documented there had been no incidents. The other MBMF</p>	F 309	<p>Also, the Interdisciplinary (ID) team reviewed residents with behavioral monitors and adjusted care plans and behavior monitors to include additional types of delusions and other behaviors identified.</p> <p><b>Systemic Changes</b> The Staff Development Coordinator (SDC) and/or Director of Nursing Services (DNS) has educated the ID team and nursing staff regarding provision of care and services to include, but not limited to</p> <ul style="list-style-type: none"> <li>Identifying non-pharmacologic interventions specific to each resident for sleep hygiene through interview and observation, updating the care plan, and implementation of the plan to aid in sleep.</li> <li>ID team and nursing staff to communicate to social services and nursing management when additional behaviors and/or delusions are present through stop-n-watch alert process.</li> <li>Licensed nurses to coordinate update of behavioral monitors and care plans with social service.</li> </ul> <p><b>Monitoring</b> The DNS and/or designee will review daily physician orders, stop-n-watch communication, nursing alerts, and 24 hour summary for changes in resident sleep patterns/use of hypnotics and changes in behaviors/medication. Residents with changes or at least two current residents will be reviewed each week for 12 weeks beginning the week of June 13 for:</p>	

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F 309	<p>Continued From page 2</p> <p>started on 4/4/14 and identified the target behavior as "Delusions overtly stressed by perceives sabotage of court reporter occupation." The form documented 1 day (1 incident) on day shift, 5 days (15 incidents) on evening shift and 0 days on night shift for the remainder of the month.</p> <p>The MBMF for 5/1/14 -5/6/14 documented the same delusions as the 4/14 MBMF related to sabotage of court reporter occupation and documented 0 days with delusions.</p> <p>On 5/7/14 at 10:15 a.m., CNA #2 stated the resident's delusions were thinking he was at home, he had to fix his truck or "involved communion." When asked about the resident having delusions about being a court reporter the CNA stated no but the resident had "blessed her a few times." CNA #2 stated the delusions were stressful to the resident.</p> <p>On 5/7/14 at 10:30 a.m. the Activity Director (AD) was asked about the resident's delusions. The AD stated the resident "yells out for his family...in his own little world." The AD stated the resident used to be a deacon in his church and will want to go to Mass.</p> <p>On 5/7/14 at 11:00 a.m. CNA #3 stated the resident's delusions were he had "to find his car." The CNA said the delusions were upsetting to the resident and he would become verbally or physically aggressive.</p> <p>On 5/7/14 at 8:55 p.m. CNA #4 was observed standing by the resident near the reception area of the facility. The CNA stated the resident's delusions were he thinks his wife and daughter</p>	F 309	<ul style="list-style-type: none"> <li>Individualized care plans for non-pharmacological sleep hygiene intervention</li> <li>Alignment of staff interview and behavioral monitor that reflects resident current behavior and/or delusion.</li> </ul> <p>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.</p> <p><b>Completion Date</b> June 13, 2014</p>		

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F 309	<p>Continued From page 3</p> <p>are "here or he is in the military."</p> <p>On 5/8/14 at 1:00 p.m. the DON was informed the resident's Care Plan for delusions was not clear as to what was to be documented. The DON stated the resident did have delusions regarding being a court reporter. The DON was informed the CNA's did not identify the resident having delusions regarding being a court reporter but numerous other delusions. The DON stated the Care Plan and MBMF's needed to identify all of the delusions to ensure accurate information regarding the resident's delusions.</p> <p>b. The resident's May 2014 recapitulation Physician's Orders included an order for Restonil (hypnotic) 7.5 mg at bedtime for sleep with a start date of 3/28/14.</p> <p>The resident's 4/30/14 Care Plan for insomnia included interventions to administer medication as ordered and monitor for effectiveness, provide a quiet environment for sleep and to document the hours of sleep. There was no evidence that non-pharmacological interventions such as using sleep hygiene techniques &amp; individualized sleep routines, listening to music, or bathing at bedtime were tried prior to implementation of the medication.</p> <p>On 5/8/14 at 1:00 p.m. the DON was informed the resident's Care Plan for insomnia included an intervention to provide a quiet environment for sleep. The surveyor stated a quiet environment at night was expected for every resident and not an individualized intervention for Resident #3. The DON stated she would see if any other interventions were implemented. The facility provided no further information.</p>	F 309			

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F 309	Continued From page 4	F 309			
F 323 SS=E	<p>On 5/9/14 at 11:00 a.m. the Administrator, DON and Nurse Consultant were informed of the above concern. No further information was provided by the facility.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interview it was determined the facility failed to implement interventions including adequate supervision and/or assistive devices to reduce the risk of falls for 1 of 6 (#3) sampled residents. This placed the resident fell at risk for serious injury and/or decline in physical functioning. Additionally, the facility failed to ensure that harmful chemicals, that could be ingested by residents with cognitive impairments, were secured. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 9/1/10 and readmitted on 3/22/12 with diagnoses which included senile dementia and delusional disorder.</p> <p>The resident's 4/21/14 quarterly MDS assessment documented the resident was</p>	F 323	<p><b>F-323 Specific Residents</b></p> <p>Resident #3 care plan is updated to include current interventions that address the root-cause of his falls. Observation by the ID team reveals the plan is consistently implemented at the resident bedside.</p> <p>The shower room door locks are updated to a keyless entry that locks when closed. Observation by the ID team reveals that the shower rooms are locked with potentially hazardous chemicals consistently secured.</p> <p><b>Other Residents</b></p> <p>The ID team reviewed other residents with repeat falls. Care plans were updated to address the root-cause of the fall. Observation by the ID team validates interventions consistently implemented.</p> <p>Observation by the ID team reveals that the shower rooms are locked with potentially hazardous chemicals consistently secured.</p> <p><b>Systemic Changes</b></p> <p>The SDC and/or DNS has re-educated the nursing staff regarding fall prevention plans to include, but not limited to</p> <ul style="list-style-type: none"> <li>• Identification of the root-cause of the fall. Then develop a new intervention to address the root-cause after each fall.</li> <li>• Validation that the plan is consistently implemented through nursing rounds.</li> </ul>		

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F 323	<p>Continued From page 5</p> <p>severely cognitively impaired and required extensive assistance of 2 people for bed mobility, transfers and walking in the corridor and he was totally dependent on 2 staff for toileting. The assessment documented the resident had 2 or more non injury falls.</p> <p>The resident's current Care Plan for falls, initially implemented on 3/22/12, included the following interventions and implementation dates:</p> <p>9/20/12 - Wife visits daily and assists with safety concerns, resident in front lobby for increased supervision when awake, 1:1 as needed to keep resident safe.</p> <p>4/6/13 - Floor Mat Alarm centered by bed when in bed.</p> <p>5/13/13 - Offer to lay resident in bed when resident asks or tries to lay on floor.</p> <p>10/16/13 - Remind wife to alert staff of any safety concerns to prevent falls.</p> <p>11/22/13 - Body pillow to left side of bed for boundary</p> <p>Date not provided - Provide 1:1 when restless.</p> <p>3/5/14 - Tab alarm in wheelchair to alert staff of self transfer attempts.</p> <p>3/20/14 - If the resident desires assist to sit on the floor and reapproach every 5 minutes to see if will allow transfer back to bed or chair.</p> <p>10/16/13 - Staff not to awake resident while sleeping due to increased...restlessness.</p>	F 323	<ul style="list-style-type: none"> <li>Alarm monitoring is added to the Medication Administration Record (MAR) for licensed nurse validation each shift.</li> <li>1:1 and/or line of sight supervision does not allow a staff person to leave the role of resident supervision without another staff assuming that role.</li> <li>Review of the updated fall prevention plan by the clinical management team over the next 7 days for effectiveness.</li> <li>If the plan becomes ineffective, adjustments or additional interventions are implemented to prevent additional falls.</li> </ul> <p>In addition, nursing and therapy staff was educated on new keyless entry to showers and re-educated regarding keeping the shower rooms and chemicals locked when not in use. Licensed nurses and ID team educated to include validation checks while on rounds.</p> <p><b>Monitoring</b></p> <p>The DNS and/or designee will review resident events, stop-n-watch communication, nursing alerts, and 24 hours summary for residents with falls or change of condition. Residents with new falls, change of condition, or at least two current residents will be reviewed each week for 12 weeks beginning the week of June 13 for</p> <ul style="list-style-type: none"> <li>identification of root-cause,</li> <li>plan for fall prevention,</li> <li>implementation of interventions,</li> <li>and review for plan effectiveness.</li> </ul>	

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NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHABILITATION - WEISER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>331 EAST PARK STREET WEISER, ID 83672</b>		
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F 323	<p>Continued From page 6</p> <p>The resident's medical record included 8 Post-Event Investigations/Interviews reports (IR) of non injury falls between 10/15/13 and 3/26/14. The IRs documented the following:</p> <p>10/15/13 at 9:35 p.m. - The resident was found sitting by the bed and had "missed alarm mat by a few inches." The IR documented the floor mat alarm was not placed correctly. The corrective action was training for staff to place the mat correctly. NOTE: This intervention was first implemented on 4/6/13.</p> <p>11/22/13 at 1:35 a.m. - The resident scooted to the edge of the seat in the wheelchair and "slid down the foot rest to the floor." The corrective action was for 1:1 supervision when the resident was restless. NOTE: According to the Care Plan 1:1 supervision had been in place since 9/20/12.</p> <p>12/10/13 at 8:50 p.m. - The resident was sitting in his wheelchair at the nurse's station. The IR documented the resident was "moving around (fidgeting/restless)" and slid to the floor. The nurse "entered the nurse station to hear thump." The corrective action was to offer pain medication when restless. A physical therapy evaluation was completed for correct positioning in the wheelchair on 12/16/13. NOTE: The corrective action for the previous fall was 1:1 supervision when the resident was restless. The IR documented the resident was restless and placed at the nurses station for supervision, however, the nurse left the area and was just returning to the nurses station when the resident fell.</p> <p>12/20/13 at 2:35 p.m. - The resident's wife was visiting and had left the room to request</p>	F 323	<p>The ED, DNS, and/or designee will monitor on daily rounds that shower rooms and chemicals are locked when not in use.</p> <p>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> <p><b>Completion Date</b> June 13, 2014</p>	

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:  135010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/09/2014
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F 323	<p>Continued From page 7</p> <p>assistance for the resident when he requested a bath. The resident was found sitting on the floor in front of his recliner. The IR documented the resident had been restless. The corrective action was to educate the wife to use the call light for assistance for the resident.</p> <p>12/22/13 at 10:00 a.m. - The resident was sitting beside the bed on the floor alarm which had not been turned on. The corrective action was staff were trained to make sure the floor mat alarm was on.</p> <p>1/18/14 at 9:40 a.m. - The resident was found on the floor mat with the alarm sounding. The IR documented the resident's adult incontinence brief was wet and he gets "agitated" when he is woke up. The Care Plan was updated to not wake the resident at night to change the incontinence brief.</p> <p>NOTE: The resident fell after he woke up and his adult brief was wet. The Care Plan was revised to not change the resident at night. The intervention did not address the resident attempting to get up at 9:40 a.m.</p> <p>3/19/14 at 10:30 p.m. - The resident was attempting to crawl out of his chair. The CNA assisted the resident to sit on the floor. The corrective action was if the resident desires to sit on the floor the staff will assist him to the floor and check on him every 5 minutes to transfer him back to bed or his wheelchair.</p> <p>3/26/14 at 5:10 a.m. - The resident was sitting on the floor next to his bed. The floor mat alarm was not turned on. The corrective action was staff were trained to check to ensure alarms every shift.</p>	F 323		
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F 323	<p>Continued From page 8</p> <p>On 5/8/14 at 1:00 p.m., the DON was informed that for several of the falls the interventions had not been implemented (alarms not on, placed correctly or 1:1 supervision provided) and informed placement at the nurses station did not always ensure constant supervision for the resident. The DON was also asked why the only corrective action for the 12/20/13 incident was for the wife to be told to use the call light. The DON agreed the facility was responsible to keep the resident safe, not the wife.</p> <p>The resident had 8 falls in 5 months. The facility failed to ensure the floor alarm mat worked properly when the resident attempted to get out of bed for 2 of the 8 falls. Additionally, the 12/10/13 intervention to provide 1:1 when the resident was restless was not consistently implemented. The intervention to not wake the resident at night did not address the resident had fell at 9:40 a.m. due to a wet adult brief. Also the facility held the resident's family member responsible to prevent falls without ensuring interventions the facility was responsible for were implemented.</p> <p>On 5/9/14 at 11:00 a.m., the Administrator, DON and nurse consultant were informed of the above concern. The facility provided no further information.</p> <p>2. On 5/5/14 at 11:00 AM, the shower room labeled "Century Tub" located next to room 118 was found to be empty and unlocked. Inside the tub room on the shelf to the left of the door was a can of Arrid XX, antiperspirant aerosol spray. The can was labeled, "Avoid mouth an eyes. If swallowed, Get medical help or contact a Poison</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>Control Center right away." Also, an unsealed container of Sani-Cloth Bleach Germicidal Disposable Wipes was found. This bottle was labeled, "Hazardous to human and domestic animals. Causes moderate eye irritation. Avoid contact with eyes and clothing. Wash thoroughly with soap and water after handling and before eating... If consumed, Call poison Control Center or a doctor for treatment advice." At the back of the shower room was a five tiered closed cabinet which was unlocked and contained 10 bottles of shampoo and conditioner as well as shaving creams, razors, perfumes, combs and a box of clingwrap.</p> <p>On 5/5/14 at 11:05 AM, the DON was notified of the hazard issue. She entered the unlocked shower room, moved the cleaner and the visible bottles and sprays into the cabinet at the far end of the room. She said, "Usually it is locked, was it unlocked?" and locked the door after exiting the room.</p> <p>On 5/5/14 at 11:10 AM, the shower room across from room 220 was unlocked. Inside the shower room and stacked on the shelves immediately inside the room to the right were 11 bottles of shampoo, conditioner, and body wash, a bottle of Aarid XX antiperspirant aerosol spray, perfume and an unsealed bottle of Sani-Cloth Bleach Germicidal Disposable Wipes.</p> <p>On 5/5/14 at 11:20 AM, the DON was notified of the issue. When the DON and surveyor approached the shower room across from room 220, a staff member was observed to lock it saying, "Someone just used the shower."</p> <p>On 5/7/14 at 6:30 PM, the Administrator and DON</p>	F 323			

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F 323	Continued From page 10	F 323		
F 333 SS=D	<p>were informed of the issue. No further information was provided.</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medication pass observation, staff interview, facility policy review and medical record review it was determined the facility failed to ensure a resident was free from significant medication errors. This was true for 1 of 10 residents (#11) observed for medication pass. This deficient practice had the potential for more than minimal harm if the resident experienced a hypoglycemic event due to receiving insulin over an hour prior to meals.</p> <p>The facility policy regarding Novolog Flexpen Syringe documented the following, "...Inject this medication under the skin as directed by your doctor, usually 5 to 10 minutes before meals... Because this insulin is fast-acting, do not use insulin aspart if you are unable to eat right after the injection... Not eating after a dose of this insulin may lead to low blood sugar..."</p> <p>Resident #11 was admitted to the facility on 11/21/12 with diagnoses which included diabetes mellitus.</p> <p>The resident's 4/2012 Physician's Orders included an order for NOVOLOG (INSULIN ASPART) SLIDING SCALE WITH MEALS...</p>	F 333	<p><i>D.S.</i></p> <p><b>F-333 Specific Resident</b> <i>Per Administrator phone call 6/4/14 @ 16:25</i></p> <p>Resident #8 is observed by the clinical management team to be served his meal within 60 minutes of insulin administration.</p> <p><b>Other Residents</b> Other residents on insulin are observed by the clinical management team to be served their meal within 60 minutes of insulin administration.</p> <p><b>Systemic Changes</b> SDC and/or DNS have re-educated the licensed nurses regarding insulin, to include but not limited to</p> <ul style="list-style-type: none"> <li>• Providing insulin injections no greater than 30 minutes prior to scheduled meal times.</li> <li>• This allows for an occasional delay in meal consumption by the resident without potential for hypoglycemia.</li> <li>• If meal is delayed a substantial snack is to be provided by the licensed nurse and documented in the resident progress notes the snack and amount of consumption.</li> </ul> <p><b>Monitoring</b> DNS and/or designee will make rounds prior to meals three times each week at alternating meals for 4 weeks, then twice weekly for 8 weeks starting the week of June 13 to validate the time insulin was provided compared to the time the resident meal is served. If a delay occurs that results in greater than 60 minutes, documentation is reviewed to validate the resident was provided a substantial snack and that it was consumed.</p>	

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F 333	Continued From page 11 200-249: 3 [units], with a start date of 11/21/12.  On 5/7/14 at 3:50 PM, LN #1 was observed during medication pass to administer 3 Units of Novolog insulin into resident #11's abdomen after obtaining a blood glucose level of 214. The resident was not offered a snack when insulin was administered nor was there any food observed within reach of the resident who was in bed.  On 5/7/14 at 4:35 PM, LN #1 was asked when dinner was usually served to residents in the hallway resident #11 resides in. LN #1 said, "Dinner starts at 5:30 PM in the dining room. Room trays are passed 15 or 20 minutes after 5 PM."  On 5/8/14 at 1:40 PM, the DON and Corporate Nurse Consultant were informed of the observation. The DON said, "It's over an hour early; It is too early to give insulin."	F 333	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.  <b>Completion Date</b> June 13, 2014		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME  Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.  There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.  The facility must offer snacks at bedtime daily.  When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial	F 368	<b>F-368</b> <b>Specific Residents</b> Resident # 9 & 12 are offered a bedtime snack daily. Interview/observation by the ID team validate snacks are offered prior to 8:00 pm daily.  <b>Other Residents</b> Interview/observation by the ID team validates that residents are offered a bedtime snack daily.		

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F 368	<p>Continued From page 12</p> <p>evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews, and staff, resident and family interviews, it was determined the facility failed to ensure residents were offered a snack at bedtime/nighttime for 1 of 9 sample residents (# 9), 3 family members, two of whom wished to remain anonymous, a random resident (#12) and 6 of 6 residents who attended the Resident Group meeting with the surveyors. This had the potential for harm because the residents may be hungry and not get the opportunity for a snack. Lack of a nighttime snack may result in the altered nutritional status of residents. Findings included:</p> <p>1. On 5/6/14 at 1:30 PM, the resident group was asked about nighttime snacks. Six of 6 residents present stated they were not offered a snack at nighttime, but stated there were snacks available if they requested one. One anonymous resident said, "They never come to me and offer [a bedtime snack] to me, but they do when my blood sugar is too low."</p> <p>2. On 5/7/14 at 8:25 PM, Resident #12 was asked if she was offered a nighttime snack. She said, "Oh yes, I'm a diabetic. All I have to do is hit my button and ask and they bring it right in." When asked if the facility brings or offers her a snack when she does not ask for one she said, "No, but I always have/store food here in my dresser. All I have to do is hit my call light."</p>	F 368	<p><b>Systemic Changes</b> SDC and/or DNS have re-educated evening shift nursing and kitchen staff regarding offering bedtime snacks to residents. Each evening the kitchen staff assembles a cart with bedtime snacks. Nursing staff present the cart room to room offering a bedtime snack to each resident. Snacks are to be offered prior to 8:00 pm. Nursing assistants document the bedtime snack indicating acceptance, refusal, or noting the resident was sleeping.</p> <p><b>Monitoring</b> The DNS and/or designee will make rounds two evenings each week and ask five residents each week for 4 weeks to validate bedtime snacks are offered. In addition, documentation will be reviewed twice weekly for 4 weeks then once weekly for 8 weeks beginning the week of June 13 to validate documentation of bedtime snack offerings.</p> <p>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> <p><b>Completion Date</b> June 13, 2014</p>		

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F 368	Continued From page 13 3. On 5/7/14 at 8:37 PM, Resident #9 was asked if he was offered a nighttime snack. He said, "I go up and get it." When asked if he was offered one or if they bring snacks to him he said, "No, but we know it's available." 4. On 5/7/14 at 5:40 p.m., Resident #3's family member stated she was frequently at the facility when the resident went to bed and "sometimes" the resident was offered a snack.  5. On 5/7/14 at approximately 8:30 p.m. two family members, who wished to remain anonymous were visiting a resident. Both family members stated they were frequently at the facility in the evening when the resident went to bed. Both of the family members stated they had never seen the facility offer the resident a snack.  On 5/7/14 at 8:15 p.m. CNA #5 was asked about snacks at bedtime. CNA #5 stated most residents will ask for a snack.  On 5/7/14 at approximately 9:00 p.m., the Administrator, DON and Nurse Consultant were informed of the above concern. The facility provided no further information.	F 368		
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 information to identify the resident; a record of the	F 514	<b>F-514 Specific Residents</b> Resident #1 and #2 medical records were not adjusted as legally no retroactive changes can be made. DNS observation validates that current MAR's/TAR's are complete with orders initialed when carried out.  <b>Other Residents</b> DNS review shows other resident records had similar deficient practices with incomplete MAR/TAR's where	

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F 514	<p>Continued From page 14</p> <p>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 medical 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 2 of 6 (#s 1 and 2) sampled residents. The 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 #1 was readmitted on 7/25/13 with multiple diagnoses which included joint replaced knee and neuropathy.</p> <p>The resident's May 2014 Physician's Orders documented, "Chart mL [milliliters] taken by resident [every] shift," initiated on 4/1/14; and "Calmoseptine Cream to buttocks topical [every] shift preventative," initiated on 8/30/13.</p> <p>The resident's Care Plan under the focus area of "Skin/Tissue integrity impaired: potential," documented the goal was initiated on 7/25/13: "Will have intact skin." An intervention documented was "Air mattress on bed with setting at 3."</p> <p>Resident #1's MAR and TAR for April 2013</p>	F 514	<p>nursing initials were not present for all orders carried out. 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 complete initials for orders carried out. Before the end of the shift, initials are corrected by the nurse who carried out the order.</p> <p><b>Systemic Changes</b> The SDC and/or DNS re-educated licensed nurses regarding complete and accurate documentation of the medical record, to include but not limited to, initial of each order carried out. The on-coming nurse is responsible to review the MAR/TAR documentation with the off-going nurse to validate each order that is carried out has a corresponding nurse initial. Any errors are correct by the nurse who carried out the order before leaving shift.</p> <p><b>Monitoring</b> The DNS and/or designee will review MAR/TAR's daily for two weeks, then twice weekly for 6 weeks, then once weekly for 4 weeks beginning the week of June 13 to validate the nurse initials each order that is carried out.</p> <p>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> <p><b>Compliance Date</b> June 13, 2014</p>	

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F 514	<p>Continued From page 15</p> <p>documented:</p> <p>*"Nystatin cream 1GM Cream topical twice a day [related to] red groin." The form was blank 16 of 49 opportunities;</p> <p>*"Calmoseptine Cream to buttocks topical [every] shift preventative." The form was blank of 7 of 90 opportunities; and</p> <p>*"Air mattress on bed with setting at 3." The form was blank of 10 of 90 opportunities.</p> <p>2. Resident #2 was admitted to the facility on 11/29/07 and readmitted on 8/15/12 with diagnoses which included dementia with behavior disturbance, diabetes and chronic airway obstruction. The resident received all of her nutrition via a feeding tube.</p> <p>The resident's May 2014 recapitulation Physician's Orders included orders to check the residuals (food left in stomach) prior to starting the tube feeding, to flush the tubing with water every 6 hours and Glucerna formula for 18 hours each day.</p> <p>The resident's April 2014 Medication Record (MR) documented the formula was started at 4:00 p.m. on 4/9/14 and 4/12/14, however the stop time of 10:00 a.m. was not documented. In addition, the MR did not document:</p> <ul style="list-style-type: none"> <li>* Residuals were checked on 4/2/14 or 4/4/14 at 10:00 p.m.</li> <li>* Water flushes were completed on 4/9/14, 4/18/14 at 6:00 a.m. and 4/23/14 at 12:00 p.m.</li> <li>* The placement of the tube was checked on 4/5/14, 4/8/14 and 4/13/14 at 10:00 p.m.</li> </ul> <p>On 5/9/14 at 9:30 a.m. the DON was asked about the above concerns. The DON stated the nurses had forgot to document the treatments/checks</p>	F 514		

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F 514	Continued From page 16 had been completed.	F 514			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001830</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2014</b>
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NAME OF PROVIDER OR SUPPLIER: **KINDRED NURSING & REHABILITATION - WEI**  
STREET ADDRESS, CITY, STATE, ZIP CODE: **331 EAST PARK STREET WEISER, ID 83672**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS  The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual State licensure survey of your facility.  The surveyors who conducted the survey were: Sherri Case, BSW, LSW, QIPD, Team Leader Jana Duncan, RN, MSN.  The survey team entered the facility on May 5, 2014 and exited on Friday, May 9, 2014.	C 000	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
C 297	02.107,05,a Bedtime Snacks  a. Bedtime snacks of nourishing quality shall be offered, and between-meal snacks should be offered. This Rule is not met as evidenced by: Refer to F 368 as it relates to bedtime snacks.	C 297	<b>C - 297</b> See POC for F368.	
C 342	02.108,04,b,ii Toxics Stored Under Lock and Key  ii. All toxic chemicals shall be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Refer to F323 regarding chemical hazards in unlocked shower rooms and closets.	C 342	<b>C - 342</b> See POC for F323	
C 422	02.120,05,p,vii Capacity Requirements for Toilets/Bath Areas  vii. On each patient/resident floor or nursing unit there shall be at	C 422	<b>C-422</b> <b>Specific Residents</b> The facility has 3 permanent shower and bathing units which meets the needs of our current resident census:	

RECEIVED

JUN - 2 2014

FACILITY STANDARDS

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

*Gerald Bose*

TITLE

*Executive Director*

(X6) DATE

*5/30/14*

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001830</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2014</b>
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C 422

Continued From page 1

least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water.

This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility did not have one bathing facility for every 12 licensed beds.

The facility was licensed for 76 beds, which required 7 bathing facilities. The facility had only 3 permanent bathing facilities, plus 3 temporary bathing facilities stored in the basement.

On 5/9/14 at 10:30 AM, the Administrator was interviewed regarding the concerns. He stated that there are 3 permanent bathing facilities and 3 temporary bathing facilities in the basement if needed. No issues were identified during the survey process related to this concern.

C 422

**Other Residents**  
If our census increases to greater than 36 residents, we have portable shower units on site that can be used to meet the needs.

**Systemic Changes**  
All portable shower units will be moved from our basement storage to an accessible area for staff to use as needs arise.

**Monitoring**  
The Executive Director (ED) is requesting the waiver be renewed to satisfy the C 422 rule as we do not have enough shower units to meet our current licensed beds; however we do have adequate shower units to meet our current census. If our census increases, the ED will direct portable bathing units be put into service.

Any concerns will be addressed immediately and reported to the PI Committee.

**Compliance Date**  
June 13, 2014

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: Refer to F309 as it relates to residents with dementia.

C 784

~~C-748~~ 784  
See POC for F309

*per phone*

*Conversation with Administrator on 6/5/14 at 3:30 PM BB*

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001830</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2014</b>
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C 790	Continued From page 2	C 790		
C 790	02.200,03,b,vi Protection from Injury/Accidents  vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 as it relates to preventing accidents.	C 790	<b>C - 790</b> <b>See POC for F323</b>	
C 798	02.200,04,a MEDICATION ADMINISTRATION Written Orders  04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following:  a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule is not met as evidenced by: Please refer to F333 as it pertains to medication errors.	C 798	<b>C - 798</b> <b>See POC for F333</b>	
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: Please refer to F514 as it pertains to clinical records.	C 881	<b>C - 881</b> <b>See POC for <del>514</del> F514</b>	

*per phone conversation with Administrator on 6/5/14 at 3:30 pm B.B.*