



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7007 3020 0001 4044 7106

June 7, 2013

Todd "Shane" Bell, Administrator
Kindred Nursing & Rehabilitation - Nampa
404 North Horton Street
Nampa, ID 83651

Provider #: 135019

Dear Mr. Bell:

On **May 24, 2013**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Kindred Nursing & Rehabilitation - Nampa 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 a widespread deficiency 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

Todd "Shane" Bell, Administrator
June 7, 2013
Page 2 of 4

sign both Form 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 20, 2013**. Failure to submit an acceptable PoC by **June 20, 2013**, may result in the imposition of civil monetary penalties by **July 10, 2013**.

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

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

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

Todd "Shane" Bell, Administrator
June 7, 2013
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*.

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 28, 2013 (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 28, 2013**. A change in the seriousness of the deficiencies on **June 28, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 28, 2013** includes the following:

Denial of payment for new admissions effective **August 24, 2013**. [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 24, 2013**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; 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.

Todd "Shane" Bell, Administrator
June 7, 2013
Page 4 of 4

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 24, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the 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 20, 2013**. If your request for informal dispute resolution is received after **June 20, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,



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

LT/dmj
Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135019	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 5/24/2013
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHAB - NAMPA		STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 514	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>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.</p> <p>The clinical record must contain sufficient 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 observation, record review, and staff interview, it was determined the facility failed to ensure a resident's Physician's Orders (recapitulation) were up to date. This affected 1 of 9 (#5) sampled residents reviewed for accuracy of Physician's Orders. Findings included:</p> <p>Resident #5 was originally admitted to the facility on 6/14/10 and readmitted on 9/7/10 with multiple diagnoses including rheumatoid arthritis, closed fracture of the lumbar vertebra, and osteoporosis.</p> <p>The resident's May 2013 Physician's Orders (recapitulation) contained a 1/23/13 order for a "Back Brace."</p> <p>The resident's care plan did not include the use of a back brace.</p> <p>During the survey process the resident was not observed with a back brace and a back brace was not observed in the resident's room.</p> <p>On 5/22/13 at 9:40 a.m., the surveyor informed the DON and the LN #1 Resident #5's Physician's Orders included an order for a back brace. Both the DON and the LN said the use of the back brace was trialed at one time but was determined as not helpful for the resident. The DON stated, "We will contact the physician to discontinue the order for the back brace and update the Physician's Orders."</p> <p>On 5/24/13 at 12:30 p.m., the Administrator was informed of the finding. The facility did not provide additional information.</p>		

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

The above isolated deficiencies pose no actual harm to the residents

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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/24/2013
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHAB - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual recertification survey and complaint investigation of your facility.</p> <p>The surveyors conducting the survey were: Lorraine Hutton RN, Team Coordinator Karen Marshall, MS, RD, LD Amy Jensen, RN</p> <p>Survey Definitions: ADL = Activities of Daily Living AFO = Ankle Foot Orthotic BIMS = Brief Interview for Mental Status CAA = Care Area Assessment CNA = Certified Nurse Aide DNS/DON = Director Nursing Services/Director of Nursing FDA = Food and Drug Administration HVAC = Heating, Ventilation, and Air Conditioning IDT = Interdisciplinary Team LN = Licensed Nurse LSW = Licensed Social Worker MD = Medical Doctor MG = Milligram MAR or MR = Medication Administration Record MDS = Minimum Data Set assessment PRN = As Needed RN = Registered Nurse TAR = Treatment Administration Record Ted Hose = Thromboembolism-deterrent Hose</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 - Nampa 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>	
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an</p>	F 157	<p>F 157</p> <p>Resident Specific Resident #3's physician was notified by the licensed nurse and directives received for</p>	

RECEIVED
JUN 20 2013
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Shirley Stei* TITLE: EXECUTIVE DIRECTOR (X6) DATE: 06/18/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure a resident's physician was notified when oral sodium chloride was not administered as ordered when unavailable from the pharmacy for 1 of 9 (#3) sampled residents. Not receiving sodium chloride as ordered created the potential to negatively impact electrolyte balance and cause</p>	F 157	<p>unavailable sodium chloride. Resident has been discharged.</p> <p>Other Residents Clinical staff reviewed Medication Administration Records (MARs) and residents with unavailable medications have had the physician notified and directives received.</p> <p>Facility System Staff Development Coordinator (SDC) has educated the licensed nursing staff and medical records staff regarding physician notification to include but not limited to, management of medications not available from the pharmacy. Physicians will be notified by the licensed nurse and directives received.</p> <p>Monitor The Director of Nursing Services (DNS) and/or designee will audit alternating units MARs twice weekly for 4 weeks, then weekly for 4 weeks to validate that physician notification and directives are documented when medications are unavailable from the pharmacy. The audit will be documented on the performance improvement (PI) monitor beginning the week of June 28. Any concerns will be addressed immediately and discussed with the Interdisciplinary (ID) team as indicated. The PI committee will review after 60 days and may adjust the frequency of monitoring, as it deems appropriate.</p> <p>Date of Compliance June 28, 2013</p>		

*June 28, 2013 - 10:09
DON, Pam Pen & ink
Changes to monitor weekly
x4 9 weeks then monthly
23*

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F 157	<p>Continued From page 2 other medically related concerns. Findings include:</p> <p>Resident #3 was admitted to the facility on 5/15/13 with multiple diagnoses including toxic Encephalopathy, hyponatremia, hypertension, and pituitary macroadenoma.</p> <p>Toxic Encephalopathy (neurotoxicity) occurs when the exposure to natural or manmade toxic substances (neurotoxicants) alters the normal activity of the nervous system. Pituitary macroadenoma is a benign tumor composed of glandular tissue. Resident #3's Hospital history and physical dated 5/7/13, documented, "The patient presents to the ED again on 5/07/2013, found to have a a sodium of 117 and have altered mental status. He was admitted into the Step Down Unit." Note: Resident's Sodium was below the "normal" range of [135-145] as defined by the laboratory. His "Admission Orders Record" dated 5/15/13, documented an order for,"Sodium Chloride 2 gm po BID [2 grams by mouth two times a day], for a diagnosis of hyponatremia. His "Medication Record" (MR), dated 5/15/13, documented an order for, Sodium Chloride 2 gm po BID, a.m. and hs [at bedtime]. The MR contained a box for every day of the month for nursing staff to document medication administration or identify why the medication was not given. NOTE: The resident's MR for May 2013, provided evidence the resident was not administered sodium chloride ten out of ten doses. The "Nurses Medication Notes" on the back of the MAR documented only one entry on, 5/16/13 Sodium Chloride 2 gm n/a (not available) and the</p>	F 157		

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F 157	Continued From page 3 nurse's initials. The Pharmacy, "Shipping Manifest," dated 5/20/13, documented the Sodium Chloride was received by the facility on 5/20/13. The Resident's, "Progress Notes," dated 5/15/13 through 5/20/13 did not document that the physician had been notified related to the unavailability of the Sodium Chloride or the number of doses the resident had missed. On 5/20/13 at 8:15 a.m. Resident #3 was interviewed and said he was upset because he had not received a medication the physician had ordered since Tuesday, 5/14/13. He said when he asked the nurses about the medication their continued response was, "the pharmacy does not have it." On 5/20/13 at 3:30 p.m. the DNS and the Administrator were notified and interviewed related to the "unavailability" of the sodium chloride and failure to notify the physician. The DNS stated, "This is the first time I have heard about the sodium chloride not being available." She then said it is the facility's responsibility to obtain the medication and if it is unavailable from the pharmacy it is the facility's responsibility to notify the physician and document a note on "Point Click Care" under the progress note section. On 5/21/13 the DNS provided laboratory results that documented the Resident's sodium was within the "normal" range as defined by the laboratory.	F 157			
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this	F 176	F 176 Resident Specific Residents #5's self medication assessment has been completed by the licensed nurse and the order received from the physician		

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F 176	<p>Continued From page 4 practice is safe.</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 the IDT assessed a resident as safe to self administer medication before allowing the resident to self administer medication. This affected 1 of 9 (#5) sampled residents. This practice created the potential for the resident to not receive the medication in the dosage ordered by the physician. Findings included:</p> <p>Resident #5 was originally admitted to the facility on 6/14/10 and readmitted on 9/7/10 with multiple diagnoses including rheumatoid arthritis and dry eyes.</p> <p>The resident's May 2013 Physician's Orders (recapitulation) contained a 9/7/10 order for, "Restasis Ophthalmic One drop both eyes daily in the am" for dry eyes.</p> <p>On 5/20/13 at 9:00 a.m., LN #2 was observed administering medications to Resident #5. The LN gave the resident a small plastic cup with what appeared to be medications in tablet form. The LN stayed with the resident until the resident swallowed the medications in the plastic cup. The LN then left the room, went to the medication cart, and appeared to enter initials on the resident's May 2013 MR (Medication Record). The resident was observed to move her wheelchair in front of the mirror above the sink and placed what appeared to be eye drops in her eyes. At 9:10 a.m., the surveyor informed LN #2 it</p>	F 176	<p>for self administration of eye drops. Resident care plan has been adjusted.</p> <p>Other Residents Clinical staff made rounds to validate that all medications kept in resident rooms corresponded with self medication assessments and physician orders. No additional adjustments were indicated.</p> <p>Facility System SDC has educated the licensed nursing staff regarding self medication policy to include but not limited to, the need for a documented assessment upon initiation of self medication and licensed nurse documentation requirements.</p> <p>Monitor The SDC and/or designee will make room rounds and review staff practices during medication pass weekly for 4 weeks, then biweekly for 4 weeks to validate that residents on self medication programs have the appropriate assessment and documentation. The audit will be documented on the PI monitor beginning the week of June 28. Any concerns will be addressed immediately and discussed with the ID team as indicated. The PI committee will review after 60 days and may adjust the frequency of monitoring, as it deems appropriate.</p> <p>Date of Compliance June 28, 2013</p>		

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F 176	<p>Continued From page 5</p> <p>appeared the resident placed eye drops in her eyes. The LN nodded her head in an up and down motion and stated, "[Resident #5] prefers to do her own eye drops."</p> <p>NOTE: Resident #5's clinical record did not provide evidence the IDT team assessed the resident as safe to self administer medications. The resident's May 2013 MR contained LN #2's initials for administration of the eye drops on 5/20/13 in the am.</p> <p>On 5/22/13 at 2:45 p.m., the surveyor informed LN #1 of the above observation. LN #1 stated, "[Resident #5] has not been assessed as safe to administer her own medications. I will check into it."</p> <p>On 5/23/13 at 8:10 a.m., LN #1 stated, "I spoke with [Resident #5]. She wants her independence. We will do an IDT assessment to allow her independence as much as we possibly can."</p> <p>On 5/24/13 at 12:30 p.m., the Administrator and the DON were informed of the finding. The facility did not provide additional information.</p>	F 176		
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 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</p>	F 280	<p>F 280</p> <p>Resident Specific Resident #8 and #10's care plans related to pain and sleep patterns respectively have been adjusted by the licensed nurse to meet resident current need.</p> <p>Other Residents The ID team reviewed other resident care plans and adjusted for care plan accuracy focused on pain and sleep.</p>	

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F 280	<p>Continued From page 6</p> <p>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, observation, resident and staff interviews, it was determined the facility failed to ensure resident care plans were updated and revised to reflect the residents' current identified needs. This was true for 2 of 9 sampled residents (#s 8 & 10). The failure to keep resident's care plans current with their identified needs had the potential for staff to not provide residents with individualized care and monitoring. Findings include:</p> <p>1. Resident #8 was initially admitted to the facility on 7/5/12 and readmitted on 1/23/13 with diagnoses including generalized weakness, decubitus ulcers, type II diabetes, restless leg syndrome, rheumatoid arthritis, low back pain, and cancer of the prostate.</p> <p>The resident's Quarterly MDS, dated 4/29/13, coded for occasional pain and scheduled and prn medications for pain.</p> <p>Resident #8's May 2013 recapitulated Physician's</p>	F 280	<p>Facility Systems Resident care plans are established upon admission and updated periodically with resident changes. SDC has re-educated license nurse staff and social services regarding care plan updates to include but not limited to, pain and sleep. Ongoing review will occur with quarterly care conferences and daily reporting of resident condition changes.</p> <p>Monitor The DNS and/or designee will audit two care plans per week for 8 weeks to validate accuracy and timely revisions. The audit will be documented on the PI monitor beginning the week of June 28. Any concerns will be addressed immediately and discussed with the ID team as indicated. The PI committee will review after 60 days and may adjust the frequency of monitoring, as it deems appropriate.</p> <p>Date of Compliance June 28, 2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/24/2013
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHAB - NAMPA		STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
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F 280	<p>Continued From page 7</p> <p>Orders included the following medications for pain control: Fentanyl patch 12 mcg - change every 72 hours, Tylenol 650 mg by mouth at bedtime, Gabapentin 300 mg by mouth, three times per day, lidocaine 2% jelly daily PRN for wound pain, Tylenol 325 mg 2 tablets by mouth every 8 hrs PRN pain.</p> <p>April and May MARs documented the resident received the Fentanyl patches, Neurontin, and Tylenol on a routine basis. The MARs documented few issues with breakthrough pain in April 2013 and May 2013.</p> <p>However the resident's current care plan, initiated on 1/25/13 with revision dates of 1/30/13, 2/4/13, 3/11/13, 3/13/13, 3/14/13, 3/29/13, 4/28/13, and 5/1/13 plan did not identify the causes of the residents pain, where his pain was located, that he received scheduled and PRN pain medications, any non-medicinal interventions used for pain, and/or monitoring for pain.</p> <p>On 5/22/12 at 10:55 am, the DON was interviewed regarding the resident's current care plan. The DON reviewed the care plan and stated she was surprised that the resident's pain was not addressed on the care plan. She stated, "We missed it."</p> <p>2. Resident #10 was admitted to the facility on 4/9/12 with multiple diagnoses including Alzheimer's disease with agitated behavioral features and depressive disorder.</p> <p>Resident #10's Annual 2/25/13 MDS, under "Section D - Mood," Staff Assessment of Resident</p>	F 280		

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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/24/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHAB - NAMPA	STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651
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F 280	<p>Continued From page 8</p> <p>Mood, coded "No" for trouble falling or staying asleep, or sleeping too much.</p> <p>Her Care Plan dated 4/8/13, documented the following: * focus area, "...Altered sleep patterns as evidenced by sad/pained/worried facial expressions." * goal area, "Resident #10 will have improved sleep." * intervention, "Modify sleep environment to improve sleep/rest. Monitor/document/report to Nurses/MD s/sx (signs and symptoms) of depression, including:...insomnia."</p> <p>NOTE: Review of the resident's Physician Orders (recapitulation) and 5/13 MR (Medication Record) did not provide evidence Resident #10 was administered medications for sleep. In addition, the resident did not have an active diagnosis of altered sleep pattern.</p> <p>On 5/23/13 at 4:45 p.m. the DNS was interviewed about the focus, goal, and intervention areas on the care plan dated, 4/8/13 related to sleep. The DNS said, " We are not monitoring Resident #10's sleep, she is not on a medication for sleep, and she does not have a problem sleeping." She also said the Care Plan is "generic" and "altered sleep patterns" should not be on her Care Plan.</p>	F 280		
F 309 SS=E	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment</p>	F 309	<p>F 309</p> <p>Resident Specific Resident #1, 5, 6, & 9 physician directives and care plan interventions are communicated and implemented at the bedside. Care plans were adjusted as indicated. Resident #3 has discharged.</p>	

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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/24/2013
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHAB - NAMPA		STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
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F 309	<p>Continued From page 9 and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, and record review it was determined the facility failed to ensure physician's orders and care plans were followed: This affected 5 of 9 sampled residents (#s 1, 3, 5, 6, & 9). The failure to follow physician's orders and residents' plans of care had the potential to negatively impact residents health. Findings included:</p> <p>1. Resident #3 was admitted to the facility on 5/15/13, with multiple diagnoses including chronic kidney disease, hyponatremia, hypertension, and anemia. The Resident's hospital history and physical dated 5/7/13, documented, "The patient presents to the ED again on 5/07/2013, found to have a sodium of 117 and have altered mental status. He was admitted into the Step Down Unit." Note: Resident's Sodium was below the "normal" range of [135-145] as defined by the hospital's laboratory.</p> <p>His "Admission Orders Record" and "Medication Record" (MR) dated 5/15/13, documented orders for: "Sodium Chloride 2 gm po BID [2 grams by mouth two times a day]" and a daily 2,000 ml fluid restriction, for a diagnosis of hyponatremia. a. During the initial tour of the facility on 5/20/13 at 8:15 a.m. Resident #3 stated he was very upset because he had not received a medication the physician had ordered since his admission on Wednesday, 5/15/13. The resident said when he</p>	F 309	<p>Other Residents The ID team reviewed other residents and made adjustments to care implementation as indicated. Care plans were adjusted as indicated.</p> <p>Facility Systems SDC has re-educated nursing staff regarding implementation of physician directives and care plan interventions at the bedside, to include but not limited to communication to nursing assistants & physicians, as well as following an individualized plan of care regarding fluid restrictions, brace use, blood pressure & pulse monitor, meal & fluid intake monitor, and appropriate medication administration.</p> <p>Monitor The DNS, and/or designee will audit implementation of physician directives and care plan interventions on two residents per week for 4 weeks, then one resident weekly for 4 weeks. Audits will be documented on the PI monitor beginning the week of June 28. Any concerns will be addressed immediately and discussed with the ID team as indicated. The PI committee will review after 60 days and may adjust the frequency of monitoring, as it deems appropriate.</p> <p>Date of Compliance June 28, 2013</p>	

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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/24/2013
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHAB - NAMPA		STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
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F 309	<p>Continued From page 10</p> <p>asked the nurses about the medication, their continued response was,"the pharmacy does not have it." The resident said he was upset because he was fearful his sodium level would be too low and it would prevent him from being discharged from the facility, as planned, within the next few days.</p> <p>The resident's MR for May 2013, provided evidence the resident was not administered the sodium chloride (NACL) ordered by the physician between his admission on 5/15/13 and 5/20/13 (ten out of ten doses). The "Nurses Medication Notes" on the back of the MR documented only one entry regarding why the resident did not receive the NACL- on 5/16/13, the Nurse's Medications Notes documented the NACL 2 gm was "n/a [not available]."</p> <p>In addition, the Resident's computerized progress notes on "Point Click Care," dated 5/15/13 through 5/20/13, did not document the NACL was not administered, why it was not administered, or that the physician had been notified regarding the unavailability of the NACL. Please refer to F157 for additional details.</p> <p>On 5/20/13 at 3:30 p.m., the DNS and the Administrator were notified and interviewed related to the "unavailability" of the NACL and the resident not receiving 10 out of 10 doses since his admission. The DNS stated, "This is the first time I have heard about the sodium chloride not being available." She then said it is the facility's responsibility to obtain the medication and if it is unavailable from the pharmacy it is the facility's responsibility to notify the physician and document a note on "Point Click Care" under the progress note section.</p> <p>During an interview with RN Unit Manager (RNUM) #8 on 5/20/13 at 2:00 p.m., RNUM #8</p>	F 309		

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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/24/2013
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHAB - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
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F 309	<p>Continued From page 11</p> <p>stated the resident's lab had been drawn for serum sodium levels that morning and the results were not yet available from the lab. RNUM #8 said she had been off for the last 6 days and had just followed up on NACL unavailability issue this morning, 5/20/13. When she talked to the pharmacy they told her the NACL would be delivered today.</p> <p>On 5/21/13 at 7:00 a.m., the DNS provided laboratory results that documented the Resident's serum sodium level was 141 which was within the "normal" range [135-145] as defined by the laboratory. The DNS also stated the resident's physician had decided to discontinue the NACL since his serum sodium level had improved even with the omission of the ordered NACL.</p> <p>b. On 5/21/13 at 8:50 a.m., during an interview with Resident #3, CNA #9 entered the resident's room and asked the resident if he wanted his bedside water pitcher filled. CNA #9 filled the water pitcher and returned it to the resident's room. Note: Upon request the water in the bedside water pitcher was measured by CNA #9. LPN #7 measured the water pitcher and when full, the pitcher held 650 ml's of fluid.</p> <p>The surveyor asked the resident if the facility had discussed his 2000 cc fluid restriction with him and he said they had. The surveyor asked how does the facility keep track of your fluid intake. The resident stated, "They don't, and I have no idea how much I drink during the day. I don't think they [the facility] does either." The resident said he tried to keep track of how much water he was drinking, because the doctor at the hospital said one of the reasons for his hospitalization on 5/7/13 was due to him drinking too much water.</p>	F 309			

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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/24/2013
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHAB - NAMPA		STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 309	<p>Continued From page 12</p> <p>On 5/21/13 at 9:30 a.m., RNUM #8 was interviewed about Resident #9's fluid restriction. RNUM #8 said the MR should identify the fluid restriction and the nurse on each shift should be documenting the fluid intake for their shift. She said an Intake and Output (I&O) form should have been filled out daily by the CNAs and compared with the MR. Otherwise the staff had no idea how much fluid the resident had received on each shift and/or for the entire day. RNUM #8 also said the computerized progress notes should contain documentation related to the fluid restriction.</p> <p>On 5/21/13 at 10:30 a.m., CNA #9 was interviewed about the resident's fluid restriction. She stated she had no idea the resident was on a fluid restriction or she would have checked with the nurse before filling his bedside water pitcher. She also said it is important for information, especially this kind of information when "you" are filling in on a unit that "you" do not normally work, be communicated.</p> <p>On 5/22/13 at 4:00 p.m., the DNS provided a copy of the facility's policy on fluid restriction. The policy documented when a fluid restriction is ordered, the amount of fluid per day is divided among meals, in-between meal snacks, medication administration. *Nursing is to record the amount of fluid for medication administration for each shift on the Medication Administration Record (MAR). *Nutrition services is to update the patient's meal tray card and label/list the nourishments with the amounts that are to be provided with each meal and snack.</p>	F 309		

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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/24/2013
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHAB - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 309	<p>Continued From page 13</p> <ul style="list-style-type: none"> *Remove bedside water pitcher from the patient's room. *Provide a nursing assistant flow sheet to document amount of fluid given in-between meals. *Place patient on Intake and Output (I&O) and monitor fluid intake and output. *Document in the patient's progress note, designation of fluid amounts for the patient. <p>Resident #9's 5/15/13 MAR documented his fluid restriction of 2000 ml's a day, but did not document the amount of fluid he had consumed each day from 5/15/13 to 5/20/13.</p> <p>His Initial Care Plan, initiated on 5/15/13, did not address his fluid restriction of 2000 ml's a day.</p> <p>His Intake and Output (I&O) form was reviewed and it was blank except for a sticker with the patient's information on it.</p> <p>The resident's computerized progress notes, "Point Click Care," dated 5/15/13 through 5/20/13, contained no documentation about his fluid restriction.</p> <p>2. Resident #6 was originally admitted to the facility on 3/28/12, and readmitted on 5/24/12, with multiple diagnoses including effusion of lower leg joint, hypertension (HTN), chronic kidney disease stage IV, protein calorie malnutrition, and acute venous embolism and thrombosis of unspecified deep vessel of lower</p>	F 309			

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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/24/2013
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHAB - NAMPA		STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 309	<p>Continued From page 14 extremity.</p> <p>Resident #6's 5/2/13 quarterly MDS coded cognitively intact and lower extremity impairment to both sides of the body.</p> <p>a. The resident's 5/13 Physician's Orders (recapitulation) contained, in part: - 12/18/12 order, "Use brace to RLE [Right Lower Extremity] for transfers and ambulation only, remove otherwise." -12/20/12 order, TED hose on am, off hs knee high (knee high TED hose on in the morning and off at bedtime).</p> <p>b. The resident's care plan, print date 5/21/13, contained a focus area of impaired circulation related to dependent edema. One of the focus interventions was TED hose knee high on in am, off at hs.</p> <p>NOTE: Review of Resident #6's care plan did not provide evidence the physician ordered brace to the RLE was care planned for the resident.</p> <p>During the survey process whether Resident #6 was observed sitting in his wheelchair or participating in PT, the resident was wearing what appeared to be TED hose to the right and left lower extremities. Resident #6 was observed with what appeared to be a plastic, white opaque colored brace to the left lower extremity (LLE) and a different type of device to the RLE. The RLE device appeared to have a silver colored buckle attached near the ankle area.</p> <p>On 5/22/13 at 9:30 p.m., the surveyor informed the DON the Physician's Orders contained an order for a brace to the RLE not the LLE and the</p>	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/24/2013
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHAB - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 309	<p>Continued From page 15</p> <p>use of the brace was not identified on the resident's care plan. The DON stated, "I'll check."</p> <p>On 5/22/13 at 10:03 a.m., the DON stated, "The brace is not on the care plan." At 10:09 a.m., the MDS Coordinator and the surveyor observed the resident participating in an activity. The resident had what appeared to be a plastic, white opaque colored brace to the LLE and a different type of device to the RLE. The MDS Coordinator stated, "It appears the LLE has a brace. I am not exactly sure what the device to the RLE is. We will check into it."</p> <p>On 5/23/13 at 8:45 a.m., the DON stated, "The resident has orthotics which are inserts in his shoes. We are having clarification orders completed."</p> <p>NOTE: The Physician's Order was for a brace to the RLE, not the LLE, and the use of the brace was not identified on the resident's care plan. In addition, the orthotics which the DON stated were inserts in his shoes were not included on the Physician's Orders and were not care planned.</p> <p>c. The resident's 5/13 Physician's Orders (recapitulation) contained, in part: - 5/24/12 order, Lopressor 12.5 milligrams by mouth (mg po) every 12 hours for HTN. - 5/24/12 order, Norvasc 5 mg po am for HTN.</p> <p>The resident's 5/13 Medication Record (MR) identified dates for nursing staff to document the resident's "BPP q Sunday am [Blood Pressure and Pulse every Sunday in the morning]." NOTE: Resident #6's Pulse was not documented as determined on 5/5/13. Resident #6's BPP were</p>	F 309			

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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/24/2013
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F 309	<p>Continued From page 16 not documented as determined on 5/19/13.</p> <p>On 5/22/13 at 9:50 a.m., the surveyor informed the DON the resident's pulse was not determined on 5/5/13 and BPP were not determined on 5/19/13. The DON looked at the 5/13 MR and stated, "I would expect nurses to document both BP and P every Sunday."</p> <p>On 5/23/13 at 8:45 a.m., the surveyor informed the DON the Physician's Orders did not include an order for, "BPP q Sunday am." The DON stated, "That is a nursing order we enter on the MR. We do not have a Physician's Order for this. The identified dates on the MR are for nursing staff to determine and document the resident's BPP."</p> <p>d. The resident's care plan, print date 5/21/13, identified the focus area, [Resident #6] is at increased risk of malnutrition related to renal disease and history of edema. One of the goals was, "Intake will meet needs. [Resident #6] will consume 75% of meals." One of the interventions was, "Monitor iintake {sic} of meals and snacks and record."</p> <p>The facility documented food and fluid intakes on forms titled Flow Sheet Records (FSRs). NOTE: Resident #6's 2/13 through 4/13 FSRs provided evidence the facility did not consistently record the resident's meal and fluid intakes as care planned.</p> <p>3. Resident #1 was admitted to the facility on 2/12/07 and readmitted on 4/30/07 with multiple diagnoses including schizophrenia, angina, and hypertension.</p>	F 309		

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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/24/2013
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHAB - NAMPA		STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
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F 309	<p>Continued From page 17</p> <p>The resident's 3/1/13 significant change MDS coded severe cognitive impairment and required extensive physical assistance of at least one person for ADLs.</p> <p>The resident's 5/13 Physician's Orders (recapitulation) contained a 4/9/12 order, "Weekly BP [Blood Pressure] on Monday."</p> <p>The resident's care plan, print date 5/21/13, contained a 2/21/13 focus area related to hypertension and angina. The goal was, BP will remain below 130 over 80. One of the focus interventions was, in part, "Monitor BP...q wk [Monitor BP every week]..."</p> <p>The resident's 3/13 MR identified specific dates nursing staff were to obtain the resident's weekly BP. NOTE: On 3/26/13, the resident's BP was not documented as monitored.</p> <p>4. Resident #5 was originally admitted to the facility on 6/14/10 and readmitted on 9/7/10 with multiple diagnoses including rheumatoid arthritis, closed fracture of the lumbar vertebra, and osteoporosis.</p> <p>The resident's 5/8/13 annual MDS coded cognitively intact and ADL support varied from set up help to 1 person physical assistance.</p> <p>The resident's care plan, print date 5/21/13, identified the focus area of [Resident #5] at risk for nutritional decline. One of the goals was [Resident #5] will consume an average of 75% food and beverages at meals. One of the focus</p>	F 309		

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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/24/2013
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F 309	<p>Continued From page 18</p> <p>interventions was, "Monitor/evaluate meal percentage intake via [by way of] meal intake records and observation."</p> <p>NOTE: Resident #5's 2/13 through 4/13 FSRs provided evidence the facility did not consistently record the resident's meal and fluid intakes as care planned.</p> <p>On 5/21/13 at 9:23 a.m., Resident #5 stated, "I used to weigh as much as 150 or more pounds. Now I eat enough food to keep my weight in the 140 pound range. One-hundred and forty pound range is a good weight range for me."</p> <p>On 5/22/13 at 9:16 a.m., the surveyor informed the Registered Dietitian (RD) of the inconsistent meal intake record for Resident #5. The RD reviewed the 2/13 through 4/13 FSRs and acknowledged the forms "inconsistently documented" the resident's meal and fluid intakes.</p> <p>On 5/24/13 at 12:30 p.m., the Administrator was informed of the findings. The facility did not provide additional information.</p> <p>5. Resident #9 was admitted to the facility on 4/20/13 in preparation for a hip surgery, was discharged on 4/30/13 and readmitted on 5/5/13 for after care following a joint replacement of the right hip. The resident was then discharged to the hospital again on 5/9/13 and readmitted on 5/13/13 for complications related to a non-healing surgical wound. The resident's readmit diagnoses included osteoarthritis, coagulation disorder, depression, and chronic and acute pain.</p>	F 309		

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

PRINTED: 05/30/2013
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F 309	<p>Continued From page 19</p> <p>The resident's 5/13/13 readmission orders included the following pain medications: * Tramadol 50 mg (milligrams) po (by mouth) 1-2 tablets every 6 hours PRN pain * Tylenol 650 mg po every 4 hours PRN pain * Naprosyn 250 mg PO BID (two times per day) PRN pain</p> <p>The resident's re-admission MDS, dated 5/20/13 coded the resident was cognitively impaired, had occasional pain, did not receive routine pain medications, and her pain was rated as 5 on a scale of 1 - 10.</p> <p>The resident's current care plan documented a focus area of, "Acute/chronic pain r/t [related to] Chronic Disability, fracture, Diabetes, and degenerative joint disease." The initiation date for the focus area was 5/6/13 with a revision date of 5/21/13. One of the documented goals was, "[Resident #9] will display a decrease in behaviors of inadequate pain control (irritability, agitation, restlessness, grimacing, perspiring, hyperventilation, groaning, crying)." The intervention description was, "Administer analgesic (specify medication) as per physician's orders. Give 1/2 hour before treatments or care."</p> <p>The resident's current MAR, dated 5/13/13 - 5/21/13, documented the resident was assessed at the beginning of each shift for pain per facility protocol/nursing order. All pain scores for the beginning of each shift was "0", indicating the resident was not in pain when assessed. The shifts listed were days, evenings, and nights.</p> <p>On 5/21/13 at 9:00 am, Resident #9 was</p>	F 309		

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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

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F 309	<p>Continued From page 20</p> <p>observed sitting in her wheelchair with her breakfast in front of her. The resident had a flat affect and was pale in color. CNA #4 sat with the resident while she ate. CNA #4 was asked what time the resident generally got up/into her wheelchair in the morning. CNA #4 indicated around 8:30 to 8:45 am, "When she woke up and was ready to get up." When asked when she would be going back to bed, CNA #4 stated after she finished eating.</p> <p>During an observation on 5/21/13 at 10:00 am, Resident #9 was Hoyer lifted from her wheelchair into bed by CNAs # 4 & 5. The resident moaned as the Hoyer lifted her from the chair. Once in bed, the resident was turned to her left side and then her right side, to have the Hoyer lift sling removed from under her. She was again turned from side to side to have her incontinent briefs changed and receive peri-care. While being turned from side to side and while the incontinent briefs were changed, the resident intermittently moaned. When the surveyor asked the resident if she was hurting, the resident stated "Yes," but was unable to identify where her pain was. When asked if she received pain medication prior to getting up in the morning or while she was up, the resident stated, "No."</p> <p>On 5/21/13 at 10:20 am, LN #6, was asked if Resident #9 was medicated for pain prior to receiving am cares that morning or transferring to her wheelchair for breakfast. LN #6 stated "No." The resident's MAR and Pain Medication Flow Sheets, dated 5/13/13 to 5/21/13, documented the resident had not received pain medications since 5/18/13 at 4:30 am. LN #6 was told Resident #9 had moaned with pain when</p>	F 309		

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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

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F 309	<p>Continued From page 21</p> <p>transferred to her bed and when assisted to turn from side to side. LN #6 stated she would check on the resident. LN #6 later documented she administered Tramadol 50 mg and Tylenol 650 mg to the resident at 10:30 am on 5/21/13. LN #6 documented the resident's pain rating was 7 and the resident was experiencing pain with movement.</p> <p>Further review of the resident's MAR revealed:</p> <ul style="list-style-type: none"> * Between 5/13/13 and 5/14/13, no pain medications were administered. * On 5/15/13 at 10:00 am, Resident #9 received Tramadol 50 mg and Tylenol 650 mg for a pain score of 7 and the resident was, "Crying with movement." The pain medication was documented as effective. * On 5/16/13 at 10:30 am, the resident received Tramadol 50 mg and Tylenol 650 mg for a pain score of 7 and pain with movement. The effectiveness of the pain medication was not documented. * On 5/17/13, 5/19, and 5/20/13, the resident received no pain medication. <p>Resident #9's care plan instructed staff to administer pain medication 1/2 hour before treatments or care. The resident was not consistently medicated for pain until after her cares were initiated, such as being transferred to her wheelchair per Hoyer lift, returned to bed with a Hoyer lift, and receiving peri-care and the resident complained of pain. At those times the resident's pain was scored at a 6 (on 5/18/13) or 7, on a scale of 1 to 10. On one of the 3 days the resident was medicated for pain, she was "crying" with pain. On the other two days the resident complained of pain with movement.</p>	F 309		

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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

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F 309	Continued From page 22 On 5/23/13 at 5:45 pm, the DON was notified of the concern regarding the failure to consistently administer pain medications to Resident #9 before her therapies and cares. The DON indicated she would check on the issue and respond with any clarifications. The DON/facility provided no further information regarding this issue.	F 309		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure the food preparation sink (1 of 1) was equipped with an air gap. This affected 13 of 13 (#s 1-13) sampled residents and any other residents who dined in the facility. This practice created the potential for cross-contamination of food and exposed residents to potential sources of pathogens. Findings included: 1. On 5/20/13 at 7:47 a.m. during the initial tour of the facility's kitchen, the following was observed: a. The drain of the food preparation sink was	F 371	F371 Facility Systems a. The Preparation sink was equipped with an air gap to prevent back flow. b. The two HVAC vents located above the food preparation and food service areas were cleaned the day the kitchen inspection was conducted. c. The two rows of fluorescent light fixtures were approved to be replaced with new light fixtures free of any rust or dust. Electrical Contractor is scheduling to complete project in the month of July, 2013. Monitor The Dietary Supervisor or Designee will do weekly rounds to ensure kitchen is free of dust and rust including the HVAC vents and light fixtures. <i>Pen + sink change 6/28/13</i> <i>Date of complete 6/28/13</i> <i>J Cas</i>	

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

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F 371	<p>Continued From page 23</p> <p>connected directly into the wall. The Supervisor of Nutrition Services stated, "I am not sure if there is an air gap for the sink. The Maintenance Supervisor (MS) would know for sure." At 11:28 a.m., the MS stated, "There is no air gap for the food preparation sink."</p> <p>The 2009 FDA Food Code Chapter 5, Water, Plumbing, and Waste, Subpart, 5-402.11 Backflow Prevention, (A) indicated, "Except as specified in ¶¶ (B), (C), and (D) of this section, a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed."</p> <p>b. At 7:45 a.m. two HVAC vents located above the food preparation and food service areas were observed with what appeared to be dust build-up. The Supervisor of Nutrition Services (SNS) stated, "That build-up would appear to be dust."</p> <p>The 2009 FDA Food Code, Chapter 4, Part 4-6, Cleaning of Equipment and Utensils, Subpart 602.13 Nonfood-Contact Surfaces, indicates, "Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues."</p> <p>c. At 7:50 a.m., two rows of fluorescent light fixtures were observed attached to the ceiling above the food preparation and food service areas. One row of fluorescent light fixtures was observed attached to the ceiling in the warewashing room. All of the fluorescent light fixtures were attached to the ceiling by the use of metal frames.</p>	F 371		

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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

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F 371	<p>Continued From page 24</p> <p>(1) There was visible rust on the surface of the metal frames attached to the ceiling above the food preparation area.</p> <p>(2) There was visible soil on the surface of the metal frames attached to the ceiling above the food service area. The surface also appeared uneven, not smooth, and not cleanable.</p> <p>(3) There was visible soil on the surface of the metal frames attached to the ceiling in the warewashing room. The surface also appeared uneven, not smooth, and not cleanable.</p> <p>On 5/20/13 at 7:55 a.m., the SNS acknowledged the metal frames that attached the light fixtures to the ceiling were "not clean" and the light fixture metal frames above the food preparation area were "rusty."</p> <p>The 2009 FDA Food Code, Chapter 4, Part 4-2, Design and Construction, Subpart 202.16 Nonfood-Contact Surfaces, indicates, "Nonfood-contact surfaces shall be free of unnecessary ledges, projections, and crevices, and designed and constructed to allow easy cleaning and to facilitate maintenance." Chapter 4, Part 4-6, Cleaning of Equipment and Utensils, Subpart 601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils indicated, "(C) Non food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."</p> <p>On 5/24/13 at 12:30 p.m., the Administrator and the DON were informed of the observations. The facility did not provide additional information.</p>	F 371			

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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHAB - NAMPA	STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651
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F 425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review it was determined the facility failed to ensure the pharmacy provided sodium chloride, for 1 of 9 (#3) sampled residents. Not receiving sodium chloride as ordered created the potential to negatively impact electrolyte balance and cause other medically related concerns. Findings include:</p> <p>Resident #3 was admitted to the facility on 5/15/13, with multiple diagnoses including toxic Encephalopathy, hyponatremia, hypertension,</p>	F 425	<p>F 425</p> <p>Resident Specific Resident #3's lab values indicated sodium chloride levels are within an acceptable range. The resident physician discontinued the medication. The care plan was adjusted as indicated. Resident has discharged.</p> <p>Other Residents Clinical staff reviewed MARs and residents with unavailable medications have had the physician notified as well as communication with pharmacy for medication availability dates.</p> <p>Facility Systems SDC has educated the licensed staff regarding pharmacy delivery and unavailable medications, to include but not limited to medications not received and/or unavailable over the counter medications. The Licensed nurse will contact physician and pharmacy when medications are not received or available.</p> <p>Monitor DNS and/or designee will audit on alternating units MARs twice weekly for 4 weeks, then weekly for 4 weeks to validate that medications are available and being given as ordered, any Unavailable medications have physician directives. Audits will be documented on the PI monitor beginning the week of June 28. Any concerns will be addressed immediately and discussed with the ID team as indicated. The PI committee will review</p>	
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*6/28/13
Pharmacy will be notified immediately & medication provided at that time
Sean*

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

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F 425	<p>Continued From page 26 and pituitary macroadenoma.</p> <p>Note: Toxic Encephalopathy (neurotoxicity) occurs when the exposure to natural or man made toxic substances (neurotoxicants) alters the normal activity of the nervous system. Pituitary macroadenoma is a benign tumor composed of glandular tissue.</p> <p>Resident #3's "Admission Orders Record" dated 5/15/13, documented an order for, "Sodium Chloride 2 gm po BID [2 grams by mouth two times a day]," for a diagnosis of hyponatremia.</p> <p>The Pharmacy's "Shipping Manifest," dated 5/20/13, provided evidence the Sodium Chloride was not received by the facility, from the pharmacy until 5/20/13, five days after he was admitted to the facility.</p> <p>The Resident's, "Progress Notes," dated 5/15/13 through 5/20/13 did not provide any documentation about unavailability, missed doses of medication, or that the physician was notified. On 5/20/13 at 8:15 a.m. Resident #3 was interviewed and said he was concerned his discharge, scheduled for later that week, would be delayed or he would have to go back to the hospital because he had not received one of his medications after he was discharged from the hospital and admitted to the facility, five days ago. He said, "The staff didn't really seem to make an effort to resolve the medication problem."</p> <p>On 5/20/13 at 3:30 p.m. the DNS and Administrator were interviewed. The DNS said, she was unaware the resident had not received the Sodium Chloride for 5 days, "I am shocked that I didn't know about it earlier." She said when a medication was unavailable from the pharmacy,</p>	F 425	<p>after 60 days and may adjust the frequency of monitoring, as it deems appropriate.</p> <p>Date of Compliance June 28, 2013</p>	

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

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F 425	Continued From page 27 the facility's policy was to notify the physician. The DNS also said this information should be documented on Point Click Care (PCC) progress notes. She looked on PCC and there was nothing documented about the unavailability of the Resident's medication or that the physician was notified.	F 425			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431	F 431 Resident Specific Expired, non-dated, or improperly stored insulin was destroyed by the licensed nurse. Other Residents The SDC reviewed the medication carts and medication rooms for expired, non-dated, or improperly stored insulin. Insulin was destroyed as indicated. Facility Systems SDC has re-educated licensed nurse staff regarding proper management of insulin vials and pens, to include but not limited to checking expiration dates, dating when open, and storage. Licenses nurses will validate during the end-of-shift medication cart transition. Monitor The SDC and/or designee will audit insulin pens and vials for expiration, dating, and storage weekly for 8 weeks. Audits will be documented on the PI monitor beginning the week of June 28. Any concerns will be addressed immediately and discussed with the ID team as indicated. The PI committee will review after 60 days and may adjust the		

All med carts & monitoring will be reviewed weekly for 8 weeks & 3

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

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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHAB - NAMPA		STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 431	<p>Continued From page 28</p> <p>package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to store unopened insulin properly and ensure it was not expired or outdated. This was true for 2 of 3 medication carts reviewed during medication pass. This failure created the potential for residents to receive expired insulin. Findings included:</p> <p>Note: Insulin used after the manufacturer's specified guidelines may result in decreased strength of the medication and can potentially increase residents risk for elevated blood sugars. Manufacturer's specifications are different for different insulins, for example: *Levemir, "can be kept unrefrigerated at room temperature...Unrefrigerated LEVEMIR should be discarded 42 days after it is first kept out of the refrigerator..." *Novolog, "Keep at room temperature for up to 28 days. Throw away a used Flex Pen after 28 days, even if there is insulin left..." *Lantus, "unopened or opened insulin pen at room temperature should be discarded after 28 days."</p> <p>1. On 5/22/13 at 9:30 a.m., medication cart #1 on the 300 hall contained 2 Novolog flex pens, and 1 Lantus insulin pen without a date opened or an expiration date. In addition, there was a Novolog</p>	F 431	<p>frequency of monitoring, as it deems appropriate.</p> <p>Date of Compliance June 28, 2013</p>	

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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/24/2013
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F 431	<p>Continued From page 29</p> <p>flex pen with a date opened of 4/22/13 and an expiration date of 5/20/13 and a bottle of Novolin-R with a discard date of 4/27/13. The surveyor asked LN #7 why the medication cart contained expired insulin and insulin without open or expired dates on them. She said the expired insulins had been discontinued (d/c) and they should have been pulled when the order was received to d/c them. She said the insulin without open or expired dates on them indicated the insulin had not been opened yet.</p> <p>On 5/22/13 at 10:00 a.m., the DNS was interviewed and said the extra insulin should be kept in the refrigerator until it was needed and not on the medication cart. She said the insulins on the medication cart without opened or expiration dates would have to be thrown away.</p> <p>2. On 5/22/13 at 3:00 p.m., medication cart #2 was observed with a vial/pen of Novolog R. The expiration date was 9/14/13. The surveyor asked LN #3 if the Novolog R was open. LN #3 stated, "No, it is not open. The medication is prn or as needed." The vial/pen was not labeled with the date it was removed from refrigeration so it could not be determined how long it had been stored at room temperature or when it should be discarded.</p> <p>On 5/24/13 at 12:30 p.m., the Administrator and the DON were informed of the findings. The facility did not provide any additional information.</p>	F 431			

Bureau of Facility Standards

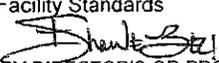
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001550	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2013
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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual licensing survey and complaint investigation of your facility. The surveyors conducting the survey were: Lorraine Hutton RN, Team Coordinator Karen Marshall, MS, RD, LD Amy Jensen, RN	C 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation - Nampa 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.	
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 for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Please refer to F371 as it related to the drain of the food preparation sink connected directly into the wall. As it related to what appeared to be visible dust build-up on the HVAC vents above the food preparation and food service areas. As it related to the rust on the frames of the fluorescent lights above the food preparation area. As it related to the uneven, not smooth, and not cleanable surfaces of the frames of the fluorescent lights above the food service area and in the warewashing room.	C 325	C 325 Please refer to POC for F 371	
C 782	02.200,03,a,iv Reviewed and Revised	C 782	C 782 Please refer to POC for F 280	

RECEIVED

JUN 20 2013

FACILITY STANDARDS

Bureau of Facility Standards


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

TITLE

EXECUTIVE DIRECTOR

(X6) DATE

06/18/13

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001550	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/24/2013
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C 782	Continued From page 1 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 care plans not individualized and/or revised.	C 782			
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 F 309 as it relates to resident's nursing care needs not being met.	C 784	C 784 Please refer to POC for F 309		
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Please refer to F 309 as it relates to physician's orders not followed.	C 788	C 788 Please refer to POC for F 309		
C 819	02.201,01 PHARMACY SERVICES 201. PHARMACY SERVICES. 01. Pharmacy Service. Each SNF and ICF shall have a written agreement with a pharmacist licensed by the	C 819	C 819 Please refer to POC for F 425		

Bureau of Facility Standards

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C 819	Continued From page 2 State of Idaho to direct, supervise and be responsible for pharmacy service in the facility. He shall be responsible for: This Rule is not met as evidenced by: Please refer to F425 as it relates to the Pharmacy not providing the facility with a medication as ordered by the physician.	C 819		
C 821	02.201,01,b Removal of Expired Meds b. Reviewing all medications in the facility for expiration dates and shall be responsible for the removal of discontinued or expired drugs from use as indicated at least every ninety (90) days. This Rule is not met as evidenced by: Please refer to F431 as it relates to monitoring expiration dates of medications.	C 821	C 821 Please refer to POC for F 431	
C 822	02.201,01,c Medication Storage and Dangerous Chemicals c. Reviewing the facility for proper storage of medications and dangerous chemicals at least every thirty (30) days and notifying the administrator of the facility of any nonconformance. This Rule is not met as evidenced by: Please refer to F431 as it relates to storing medications under proper temperature controls per the manufacturers specifications.	C 822	C 822 Please refer to POC for F 431	
C 835	02.201,02,i Meds in Possession of Resident Limitations	C 835	C 835 Please refer to POC for F 176	

Bureau of Facility Standards

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C 835	Continued From page 3 i. No medication shall be in the possession of the patient/resident unless specifically ordered by the physician on the patient's/resident's medical record, and in no case shall exceed two (2) units of dosage. All such medications shall be individually packaged by the pharmacist in units of dose, labeled with the patient's/resident's name, unit of dose, and date of distribution. The charge nurse shall maintain an inventory of these drugs on the patient's/resident's medical record. This Rule is not met as evidenced by: Please refer to F176 as it related to a resident self administering medications without an IDT assessment to determine the resident was safe to self administer the medications.	C 835			
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 related to the accuracy of a resident's Physician's Orders (recapitulation).	C 881	C 881 Please refer to POC for F 514		



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
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PHONE 208-334-6626
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June 21, 2013

Todd "Shane" Bell, Administrator
Kindred Nursing & Rehabilitation - Nampa
404 North Horton Street
Nampa, ID 83651

Provider #: 135019

Dear Mr. Bell:

On **May 24, 2013**, a Complaint Investigation survey was conducted at Kindred Nursing & Rehabilitation - Nampa. Lorraine Hutton, R.N., Amy Jensen, R.N. and Karen Marshall, R.D. conducted the complaint investigation. This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted on May 20 - 24, 2013.

The following documents were reviewed as part of the survey process:

- The closed record of the identified resident. The resident was admitted to the facility on October 11, 2012, and was discharged from the facility on November 17, 2012. While in the facility, the resident resided on the transitional short-term hall.
- The closed record of another resident, identified by first name only. This resident was admitted to the facility on October 15, 2012, and discharged from the facility on November 17, 2012.
- The facility's grievances and concerns from October 1, 2012, through November 30, 2012. Also, the facility's grievances and concerns from March 20, 2013, through May 20, 2013.
- Facility's staffing records from October 1, 2012, through November 30, 2012, and from April 28, 2013, through May 17, 2013.
- Thirteen other residents' records were reviewed for Quality of Life and Quality of Care concerns. Six residents' records were reviewed for pain medication administration. Five residents' records were reviewed for excessive weight loss or gain.

Interviews were completed with the following individuals:

- A Resident Group interview with eight residents that resided in the facility.
- Individual interviews with four other sampled residents.
- The Director of Nursing Services, the Registered Nurse (RN) identified by first name only that provided cares for the identified resident, the Physical Therapist and the facility's Registered Dietitian.

The following observations were conducted:

- Dietary services staff were observed preparing food and serving food to residents at different meal service times.
- During the initial tour and throughout the survey process, call lights and staff responsiveness to residents' call lights was observed. No problems were noted in these areas.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005819

ALLEGATION #1:

The complainant stated an identified resident did not receive pain medications. The complainant stated this happened more than once, but on Halloween, October 31, 2012, the resident requested pain medication at 11:30 p.m., and the resident did not get the pain medication until 2:30 a.m. on November 1, 2012. The complainant identified a nurse by first name only who was the nurse on duty when the resident requested pain medication on October 31, 2012, at 11:30 p.m.

The complainant stated the resident's pain level was not known but thought it was probably a "six" or "seven."

The complainant also stated a different resident, identified by first name only, did not receive 8:00 p.m. medications until the following day (date is unknown).

FINDINGS:

Eight of eight residents who attended the Resident Group interview stated that they received their medications, including pain medications, as ordered by their physician and did not have any problems or issues with nursing staff who administered the medications.

Four other sampled residents were interviewed about their medication administration program,

Todd "Shane" Bell, Administrator

June 21, 2013

Page 10 of 10

including pain medications ordered by their physicians. These four residents, who resided on three different halls, said they received their all medications, including pain medications, as ordered and had no issues with nursing staff who administered the medications.

On admission, the identified resident indicated his pain was four out of ten on a verbal pain scale. The facility care planned pain for the resident, including medications as ordered and non-pharmacological interventions.

On October 11, 2012, the identified resident's physician ordered Tramadol fifty milligrams by mouth every four hours for pain. On October 19, 2012, the resident's physician changed the Tramadol order to fifty milligrams one to two tablets by mouth four times a day as needed for pain.

The resident's medication record documented the resident requested and was administered Tramadol on October 31, 2012, at 8:40 p.m. The nurse documented the resident requested Tramadol for toe pain and rated the original pain as six out of ten. Tramadol was administered and the resident was repositioned. The resident indicated the medication and repositioning relieved his pain to a level of two.

The resident's progress notes and medication record documented the resident did not request pain medication again until November 1, 2012, at 10:00 p.m. for leg pain. Tramadol was administered and the medication was effective.

Progress notes also documented that the resident used his call light frequently for pain medications, even though the resident was aware of when he could have his pain medications.

It could not be determined that the resident had to wait for an extended time to get his pain medication.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated the facility woke people up at 7:00 a.m. for breakfast.

The facility wanted an identified resident to take Zoloft and Xanax, and the complainant thought it was so the resident would sleep at night and be up for breakfast at 7:00 a.m. in the morning.

FINDINGS:

The facility had a "Hush, No Rush" policy for breakfast, which meant that residents were provided the opportunity to eat breakfast anywhere between 7:00 a.m. and 9:00 a.m.

The residents who attended the Resident Group interview unanimously stated that the facility did not require any resident to get up at a specific time of the day. The residents who did not eat their breakfast in either of the facility's dining rooms or who slept in late were able to receive a room tray when they awoke in the morning.

Four other sampled residents stated the facility did not require residents to get up at 7:00 a.m. for breakfast. Each of the residents said breakfast was served between 7:00 a.m. and 9:00 a.m., but a resident could sleep in after 9:00 a.m. and request something to eat upon getting up for the day.

The identified resident's progress notes documented on October 21, 2012, the resident was yelling during the morning and was uncooperative with cares, and the RN was notified of the resident's anxious behaviors. On October 22, 2012, the resident used the call light multiple times prior to shift change at 6:00 a.m. The nurse on duty responded to the resident's call light, and the resident asked the nurse, "What are you doing?"

On October 22, 2012, the Licensed Social Worker (LSW) documented speaking with the resident to address the resident's yelling out, pain, refusal of therapies and treating staff poorly. During this meeting, the resident apologized to the LSW. The LSW documented that the resident's physician would be faxed for an anti-anxiety medication to help with the resident's pain and anxiety.

On October 22, 2012, at 11:50 a.m., the facility contacted the resident's physician about the resident experiencing high levels of anxiety and irritable behaviors. The resident's physician ordered Zoloft fifty milligrams by mouth every day and Xanax zero point two five (0.25) milligrams by mouth two times a day as needed. The resident's October 2012 Medication Record documented that the resident refused both medications on October 22nd, October 23rd, and October 24, 2012. The resident's physician discontinued the medications on October 24, 2012.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated an identified resident could not get up and did not have a trapeze to help him with bed mobility. The resident was dependent on staff to pull him up in bed, at the facility.

FINDINGS:

Review of the identified resident's medical record revealed that the resident required extensive assist for bed mobility and transfers. The resident's progress notes documented that the resident refused to participate in activities of daily living, such as washing his face or changing his clothes. The resident told staff that two years ago he broke his left shoulder and has had limited ability since that time. The progress notes documented that the resident preferred staff to do all his cares and was encouraged by staff to assist with personal cares. According to the resident's progress notes, the resident told staff he could not assist with cares or assist to take his clothes off or put his clothes on. The resident also told staff that he was not strong enough to help with mobility in bed.

The facility's grievances did not provide evidence that a complaint or grievance was completed because a trapeze was not provided as requested.

The Physical Therapist stated after review of the physical therapy documentation, that there was no documentation that the resident requested a trapeze.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated that an identified resident was diabetic and on a low sodium, low omega three diet, but the facility did not provide the correct diet.

For dinner on November 3, 2012, the resident received one and a half cup of macaroni and cheese, a half of slice toast, a quarter cup mixed fruit and four ounces apple juice; mostly carbohydrates. The facility also served the resident a hamburger with a bun, chips and fries or breaded chicken fingers with chips and fries. The resident was not supposed to have salmon or fish on the low omega three diet, but the facility served the resident tuna casserole.

FINDINGS:

Facility's menus reviewed for October 1 through November 30, 2012, did not provide evidence that macaroni and cheese, hamburgers, bread chicken fingers or chips and fries were on the scheduled menu to be served to residents.

Todd "Shane" Bell, Administrator
June 21, 2013
Page 10 of 10

The identified resident's attending physician ordered a regular texture limited concentrated sweets diet. The facility's staff documented that the resident's nutritional intake ranged from 25 to 100 percent. The resident refused some meals and also refused a replacement meal, when offered.

Resident's progress notes documented the resident ate independently after set up help and many times was assisted by his spouse to dine.

In addition, the progress notes documented that the resident did not follow the physician's order for the low concentrated sweets diet. Visitors frequently brought in fast food and increased snacks and drinks for the resident.

The resident's progress notes documented the resident requested food items high in carbohydrates with medication administration.

The facility's Registered Dietitian (RD) was asked about residents whose physician ordered a low omega three diet. The RD stated that since working at the facility she could not remember any physicians' order for a low omega three diet for any of the resident in the facility. The RD also stated should a physician order such a diet, she would question the physician to ensure that no mistake was made, as the human metabolism required a certain amount of omega three intake for a person to maintain their optimum health.

Review of the facility's grievances did not provide evidence that there were complaints or concerns about the facility providing residents with the correct diet.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated a resident identified by first name only (resident B) resided across the hall from the identified resident (resident A). According to the complainant, resident B told the complainant that the food was so bad the food could not be eaten and she or he lost twenty pounds in about a month. Resident B discharged from the facility on November 17, 2012.

FINDINGS:

The closed medical record of resident B was reviewed. The resident's weight varied by a total of five pounds while the resident resided in the facility. Resident B resided in the facility for approximately twenty-six days.

Todd "Shane" Bell, Administrator
June 21, 2013
Page 10 of 10

The residents who attended the Resident Group interview stated the only issue with food was with the soup that was tasty but too salty. The survey team conducted an evaluation of the soup served during the survey process. The survey team was unable to verify that the soup served was too salty.

Five residents were evaluated for excessive weight loss or weight gain. No deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant stated the facility had a difficult time getting an identified resident's Coumadin level stabilized.

FINDINGS:

On admission, the identified resident's physician ordered Coumadin on a daily basis. The resident's medical record provided evidence that the resident's PT/INRs (prothrombin time/international normalized ratio) ranged from two point four five to three point five (2.45 to 3.5) while the resident resided in the facility.

The documentation in the resident's medical record provided evidence that the facility monitored the resident's PT/INR on a frequent basis, and the resident's physician ordered Coumadin to be held several times and changed the Coumadin dosages four different times.

No deficient practice related to the administration of Coumadin was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

The complainant stated visitors and or family members provided an identified resident with snacks because the resident said he could not take pain medication, Tramadol, without eating a snack, and the facility provided cookies or nutragrain bars as a snack, which was not good for diabetics.

FINDINGS:

The identified resident's progress notes documented the resident insisted he receive two nutragrain bars with medications. The nursing staff explained to the resident he was getting too much sugar and carbohydrates, and the resident would become upset if he did not receive the nutragrain bars when he asked for the nutragrain bars.

Progress notes documented that the resident frequently asked for snacks and drinks and became very upset if he did not receive two high carbohydrate/sugary (cookies) snacks with his medications.

In addition, the progress notes documented visitors frequently brought in fast food and increased snacks and drinks for the resident to eat while the resident resided in the facility.

The residents who attended the Resident Group interview were all in agreement that the facility provided the residents with the diagnosis of Diabetes Mellitus with the appropriate snacks, especially the snacks offered at bedtime. The residents went into great details describing the different types of snacks available. In addition, the consensus of the group was that a resident could make a request from the dietary department if a resident wanted a particular snack, as long as it was allowed by the diet ordered by the resident's physician.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

The complainant stated the facility was short staffed, but did not identify a specific date or time that the facility was short staffed. The complainant tried to locate a staff to assist an identified resident, but no one was in the hall or at the nurses' station. The complainant stated a friend or family member asked staff how many staff were at the facility and was told two CNAs (Certified Nurse Aides) and a nurse. The complainant stated day shift seemed to be better staffed than evening or nights.

FINDINGS:

The facility's as worked staffing schedules from October 1 through November 30, 2012, and from April 28 through May 17, 2013, was reviewed during the survey process. The facility's staffing was within the State guidelines.

The residents who attended the Resident Group interview were asked about the staffing in the

facility. Two of the residents stated at one time last year (2012) there were concerns about staffing in the facility, and the facility took steps to correct the concerns identified by the residents. The residents stated there have not been any concerns with staffing since the residents brought it to the attention of management.

Four other sampled residents were interviewed about staffing levels in the facility. All four residents stated no concerns with staffing.

Observations conducted during the survey process did not reveal any issues with staffing in the facility.

Review of the facility's grievances did not provide evidence that residents complained about staffing in the facility.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #9:

The complainant stated an identified resident's blood glucose (blood sugar) levels were between one hundred and seven and two hundred when the resident resided at home but were sometimes over four hundred at the facility.

FINDINGS:

The identified resident's medical record provided evidence that the resident's blood glucose levels ranged from a low of fifty-nine (59) to a high of four hundred and thirty-five (435) while the resident resided in the facility. The resident's blood glucose levels were in the four hundred range on four different blood glucose checks.

On admission, the resident's physician ordered sliding scale insulin therapy for the resident. The physician ordered the facility to contact the physician when the resident's blood glucose levels were higher than four hundred and when the blood glucose levels were less than seventy.

Nursing staff documented the units of insulin that the resident received in the resident's medication record. The amounts of insulin administered were within the sliding scale therapy ranges established by the resident's physician.

The medical record also provided evidence that the facility notified the resident's physician when the blood glucose level was below seventy. According to the documentation in the medical

Todd "Shane" Bell, Administrator
June 21, 2013
Page 10 of 10

record, nursing staff notified the resident's physician and provided appropriate interventions and monitoring when the resident's blood glucose level was below seventy.

The nursing staff also notified the resident's physician when the resident's blood glucose level was above four hundred. According to the documentation in the medical record, the resident's physician responded to these notifications and ordered appropriate insulin administrations.

The documentation in the resident's medical record provided evidence that nursing staff monitored the resident for signs and symptoms of hypoglycemia and hyperglycemia on a regular basis.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The letters are somewhat stylized and slanted.

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

LKK/dmj