



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 6895**

June 19, 2013

David D. Farnes, Administrator  
Kindred Nursing & Rehabilitation - Aspen Park  
420 Rowe Street  
Moscow, ID 83843

Provider #: 135093

Dear Mr. Farnes:

On **June 7, 2013**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Kindred Nursing & Rehabilitation - Aspen Park by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) 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

David D. Farnes, Administrator  
June 19, 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 **July 2, 2013**. Failure to submit an acceptable PoC by **July 2, 2013**, may result in the imposition of civil monetary penalties by **July 22, 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.

David D. Farnes, Administrator  
June 19, 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 **July 12, 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 **July 12, 2013**. A change in the seriousness of the deficiencies on **July 12, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 12, 2013** includes the following:

Denial of payment for new admissions effective **September 7, 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 **December 7, 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.

---

David D. Farnes, Administrator  
June 19, 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 **June 7, 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:

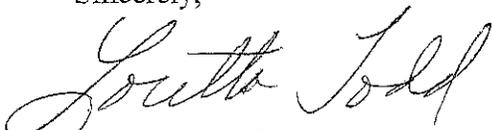
- BFS Letters (06/30/11)

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

This request must be received by **July 2, 2013**. If your request for informal dispute resolution is received after **July 2, 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

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>
---	--

(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><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the annual recertification and complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were: Lorraine Hutton, RN, Team Coordinator Nina Sanderson, BSW, LSW</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CAA = Care Area Assessment CNA = Certified Nurse Aide CVA = Cerbral Vascular Accident DNS/DON = Director Nursing Services/Director of Nursing IDT = Interdisciplinary Team LN = Licensed Nurse LSW = Licensed Social Worker MDS = Minimum Data Set MG = Milligram MAR = Medication Administration Record MDS = Minimum Data Set assessment PRN = As Needed PT/INR = Prothrombin Time/ International Normalized Ratio RN = Registered Nurse SW1 = Social Worker TAR = Treatment Administration Record W/C = Wheelchair</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 – Aspen Park does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p>	
F 241 SS=E	<p><b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p>	F 241	<p><b>F241</b></p> <p><b>Resident Specific</b> The interdisciplinary (ID) team reviewed residents # 12, 13, and 14 for dignity; resident will not receive medications in the</p>	<p style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;"><b>JUL - 1 2013</b></p> <p style="text-align: center;"><b>FACILITY STANDARDS</b></p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>David D. Bowers</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>6-28-13</i>
---	------------------------------------	-----------------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 241	Continued From page 1  This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interview, it was determined the facility failed to ensure residents' medications were not passed in the dining room, after food services began, unless specifically requested by the resident and their physician. This was true during 2 of 2 meals observed and affected Random Residents #'s 12, 13, & 14. The facility also failed to ensure that staff working in the facility did not use their personal cell phones while providing care to residents. Cell phone usage by staff was reported by 6 of 6 residents attending a group interview and 1 resident (#3) individually interviewed. The practice of passing medications during dining has the potential to affect the dignity of those receiving medications and increases the institutional atmosphere during dining for all residents. Staff using cell phones while providing cares is disrespectful to those receiving care and distracting to staff. Findings include:  1. During a lunch observation in the Tuscan dining room on 6/4/13 at 12:15 pm, LN #2 passed oral medications to Random Resident #13 before staff began placing the residents' food on the tables. However, LN #2 then approached Random Resident #14 and placed eye drops in her eyes. Food had been placed at the resident's table as well as a nearby table before she administered the eye drops. After administering the eye drops LN #2 commented that, "Lunch is here. I am going to gown up and start helping." LN # 2 put a full apron on and helped staff to continue passing the residents' food. Neither the	F 241	dining room after food services begin and caregivers will not use cell phones while providing care.  <b>Other Residents</b> The ID team monitored the dining room and patient care areas for dignity concerns. Only residents that are care planed for personal choice received medications in the dining room and cell phones are not being used in resident care areas. Care plans are updated as indicated.  <b>Facility Systems</b> The staff development coordinator (SDC) and director of nursing services (DON) have re-educated licensed nurses and staff regarding resident dignity, to include but not limited to dining service without interruption of medication pass and no personal cell phone use while providing resident care.  <b>Monitor</b> The DON and/or designee will observe the dining rooms during meal service to validate medications are not passed after meal service has begun. This will be completed daily for 1 week, then 3 times a week for 2 weeks, and once a week for 13 weeks beginning the week of 7-12-13. The review will be documented on the performance improvement (PI) audit tool. Any concerns will be addressed immediately. The PI committee will review the audit results and may adjust the frequency of the monitoring after 16 weeks, as it deems appropriate.		

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 241	<p>Continued From page 2</p> <p>resident's care plan or physician's orders documented the resident was to receive medications during meal time.</p> <p>2. As survey staff entered the Tuscan dining room during the evening meal on June 4, 2013 at 6:15 pm, GN #3 approached Random Resident #12 with oral medications. Food had already been distributed to most residents in the dining room. The resident took part of the oral medications and then refused the remainder of the medications, stating he needed to take them after his meal. GN #3 then poured and administered oral medications to Random Resident #13. The resident was agitated and refused to take the medications from GN #3. GN #3 stated she would return to him after he had finished eating. The resident stated he did not want to eat any more. Neither, Resident #12's or 13's, care plan or physician's order documented they were to receive medications during meal time.</p> <p>On June 4, 2013 at 6:30 pm, GN #3 was asked if it was usual practice to pass medications during the evening meal. GN #3 stated, "These people want to go to bed right after they eat. It's about the only time to get their medications to them. If I don't do it now, I do not know how I would get it done."</p> <p>On June 4, 2013 at 6:35 pm, the RN supervisor for the shift had her medication cart outside of the Huckleberry dining room. She was not passing medications. When asked what the facility's policy for passing medications during the evening meal, she stated, "No medication are passed after food service begins unless a resident has requested medications during the meal.</p>	F 241	<p>The Executive Director (ED) and/or designee will observe resident care areas to validate cell phones are not used during resident care daily for 1 week, 3 times per week for 2 weeks, then once per week for 13 weeks beginning the week of 7-12-13. The review will be documented on the PI audit tool. Any non-compliance issues will be addressed immediately. The PI committee will review the audit results and may adjust the frequency of the monitoring after 16 weeks, as it deems appropriate.</p> <p><b>Date of Compliance</b> July 12, 2013</p>		

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 241	Continued From page 3  3. The facility's Employee Cell Phone Use policy documented, "Personal cell phones and pagers may not be used or left on while on duty without advance approval from the supervisor...[Name of Corporation] prohibits its employees...from using cellular phones...without prior written authorization from the resident or the resident's legally responsible party and the center Executive Director. This policy is designed to promote and preserve the residents' expectation of privacy and confidentiality..."  On 6/4/13 at 9:30 AM, during a resident interview, Resident #3 stated it was customary for facility staff to use their cell phones to text one another while they were providing cares to her. Resident #3 stated she believed sometimes they were letting somebody know they needed help, but "Sometimes I think they're just talking to each other on those things." Resident #3 stated she felt as if her care was not directed towards her as an individual when this happened.  On 6/5/13 at approximately 10:50 AM, 6 of 6 residents remaining in the Resident Group interview with the surveyors stated staff routinely used their personal cell phones to text one another, while they were providing resident cares. The group believed this was the mechanism the staff used to alert one another of the need for assistance from someone to care for either themselves, or another resident. The consensus of the group was this practice left them feeling as though they were not being treated as individuals	F 241			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 241	Continued From page 4 when receiving cares, and staff could become pre-occupied with whatever was on their text message.  NOTE: Neither the individual resident nor the group expressed concern this practice was a violation of their privacy. The concerns expressed were directly related to their dignity when receiving care.  On 6/5/13 at 2:10 PM, the Administrator and DON were informed of these concerns. The DON stated, "No, that is not OK [for staff to use personal cell phones in resident rooms]." The facility offered no further information.	F 241			
F 272 SS=D	<b>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</b>  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions;	F 272	<b>F272</b>  <b>Resident Specific</b> The ID team reviewed care plans for resident # 2 and 4 with the family/resident respectively and obtained personal choices from them. Care plans are updated as indicated. Families/residents will again be included with care plan revisions and documented on the CAA with the next Minimum Data Set review. Resident # 3 has discharged home.  <b>Other Residents</b> The ID team reviewed other residents for documentation of family/resident involvement in the care plan development/update. Care plan adjustments are made as indicated, quarterly, and with significant change and will be documented with the next CAA.		

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 272	<p>Continued From page 5</p> <p>Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review it was determined the facility did not ensure comprehensive assessments included resident participation in the process of developing their own plan of care, or assessment of relevant information in support of clinical decision making for development of the residents' care plans. This was true for 3 of 7 residents (#s 2, 3, and 4) sampled for resident assessment. This deficient practice had the potential to cause more than minimal harm when residents were not given a voice in their own care plans, and relevant clinical information was not included in care plan development. Findings included:</p> <p>NOTE: Please see F 279 and F 280 as they pertain to care plan development and revisions</p>	F 272	<p><b>Facility Systems</b> The District Director of Case Management has educated licensed staff on completing CAA's, to include but not limited to including documentation of family/resident input.</p> <p><b>Monitor</b> The DON and/or designee will audit 3 CAA's per week for 2 weeks, then 2 CAA's per week for 2 weeks, then 1 CAA per week for 12 weeks beginning 7-12-13. The review will be documented on the PI audit tool. Any concerns will be addressed immediately. The PI committee will review the audit results and may adjust the frequency of the monitoring after 16 weeks, as it deems appropriate.</p> <p><b>Date of Compliance</b> July 12, 2013</p>		

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 272	<p>Continued From page 6</p> <p>1. a. Resident #2 was admitted to the facility on 1/21/13 with diagnoses which included pyelonephritis, sepsis, and a history of a CVA with expressive aphasia. Resident #2 enrolled with hospice services on 3/22/13 for a terminal diagnosis of "CVA."</p> <p>On 4/2/13, the facility completed a Significant Change of Condition (SCOC) MDS assessment for Resident #2. The triggered CAA's included Cognitive Loss, Communication, ADL Function, Urinary Incontinence, Psychosocial Well-Being, Mood State, Behavior, Activities, Falls, Nutritional Status, Dehydration, Pressure Ulcer, and Psychotropic Drug Use. With the exception of the Activities CAA, the area to provide input from the resident and/or representative for various care areas documented either, "None at this time," or, "None offered."</p> <p>b. Resident #3 was admitted to the facility on 12/31/12 following a right femur fracture, and a left wrist fracture sustained in the facility from a fall on 2/6/13. She was re-admitted to the facility on 3/2/13 following a GI bleed.</p> <p>On 3/9/13, the facility completed a readmission MDS assessment for Resident #3. The MDS triggered CAA's for Visual Function, Communication, ADL Function, Urinary Incontinence, Falls, Nutritional Status, Pressure Ulcer, Pain, and Return to Community Referral. * In each of these areas, the area to provide input from the resident and/or representative documented, "No concerns at this time." *In each of these care areas, there was an area for the facility to describe the impact of the triggered area on the resident, and the facility's</p>	F 272			

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 272	<p>Continued From page 7</p> <p>rationale for care plan decisions. The instructions for completing these areas of the CAA's documented, "Include complications and risk factors and the need for referrals to other health professionals." These areas for the triggered CAA's documented:</p> <ul style="list-style-type: none"> <li>-Visual Function, "Care plan will be developed to address and reduce/eliminate risk factors associated with decline in visual function and assist the resident in returning to PLOF (prior level of function)."</li> <li>-Communication, "Care plan will be developed to address and reduce or eliminate risk factors associated with impaired communication and assist the resident in returning to PLOF."</li> <li>-ADL Function, "Care plan will be developed to address and reduce/eliminate risk factors associated with decline in functional ADL's and assist the resident in returning to PLOF."</li> <li>-Urinary Incontinence, "Care plan will be developed to address and reduce/eliminate risk factors associated with potential for incontinence and assist the resident in returning to PLOF."</li> <li>-Similar results were documented in these areas of the form for the remaining CAA's.</li> </ul> <p>NOTE: Please see F323 as it pertains to Resident #3's falls, and her perception of her input into her plan of care.</p> <p>c. Resident #4 was admitted to the facility on 12/17/12 with diagnoses which included dementia with sundowning, infected decubitus ulcers vs. decubitus urinary incontinence, and scrotal ulcers.</p> <p>On 12/24/12, the facility completed an admission MDS assessment. The MDS triggered CAA's for</p>	F 272			

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 272	Continued From page 8 Cognitive Loss, Communication, Urinary Incontinence, Behavioral Symptoms, Falls, Nutritional Status, Dehydration, Dental Care, Pressure Ulcer, and Return to the Community Referral. *In each of these area areas, the area to provide input form the resident and/or representative documented, "No concerns at this time." *In each of these care areas, there was an area for the facility to describe the impact of the triggered area on the resident, and the facility's rationale for care plan decisions. The instructions for completing these areas of the CAA's documented, "Include complications and risk factors and the need for referrals to other health professionals." These areas for the triggered CAA's documented: -Cognitive Loss, "Care plan will be developed to address and reduce/eliminate risk factors associated with decline in cognition and diagnosis of dementia and assist resident in attaining highest level of function possible." -Communication, "Care plan will be developed to address and reduce/eliminate risk factors associated with potential decline in communication and assist resident in achieving highest level of function possible." -Urinary Incontinence, "Care plan will be developed to address and reduce/eliminate risk factors associated with urinary incontinence and assist resident in achieving the highest level of function possible." -Behavioral Symptoms, "Care plan will be developed to address and reduce/eliminate risk factors associated with s/s (signs and symptoms) of behaviors and assist resident in returning to PLOF." -Similar results were documented in these areas	F 272			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 272	Continued From page 9 of the form for the remaining CAA's.  NOTE: Please see F314 as it pertains to pressure ulcers for Resident #4.  On 6/5/13 at 2:10 PM, the DON and Administrator were asked about the expectation for the completion of these areas of the CAA's. The DON stated these areas of the CAA's should be more complete in terms of input from the resident and incorporation of clinical data for care planning decisions.  On 6/6/13 at 7:15 PM, the Administrator and DON were informed of the surveyor's concerns. The facility offered no further information.	F 272			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279	<b>F279</b>  <b>Resident Specific</b> The ID team completed a comprehensive care plan review and updated resident # 4's care plan to include wound prevention and healing.  <b>Other Residents</b> The ID team reviewed other residents to validate comprehensive care plans were in place. Care plans are updated as indicated, to include wound prevention and healing.  <b>Facility Systems</b> The SDC and DNS has re-educated licensed nurses and the ID team regarding comprehensive care plan development, to include but not limited to wound prevention and healing.		

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 279	<p>Continued From page 10 under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility did not ensure a comprehensive care plan was developed for the prevention of pressure areas. This was true for 1 of 7 residents (#4) sampled for care plans. This deficient practice had the potential to cause more than minimal harm when caregivers did not have adequate information on the care plan to prevent pressure ulcers from worsening or developing for Resident #4. Findings included:</p> <p>Resident #4 was admitted to the facility on 12/17/12 with diagnoses which included dementia with sundowning, infected decubitus ulcers vs. decubitus urinary incontinence, and scrotal ulcers.</p> <p>Resident #4's 12/24/12 Admission MDS assessment coded: *BIMS of 1, indicating severely impaired cognitive skills. *Always incontinent of urine, always continent of bowel. *Needed limited physical assistance from one person for bed mobility and hygiene. *Needed extensive physical assistance from one person for toileting. *Needed cues and supervision for ambulation. *Had 2 Stage II pressure areas present on admission, as well as other open lesions and Moisture Associated Skin Damage (MASD). *No turning or repositioning program.</p>	F 279	<p><b>Monitor</b> The DON and/or designee will review 2 skin assessments per week for 4 weeks, then 1 skin assessment per week for 12 weeks beginning the week of 7-12-13 for individualized interventions on the care plan. The review will be documented on the PI audit tool. Any concerns will be addressed immediately. The PI committee will review the audit results and may adjust the frequency of the monitoring after 16 weeks, as it deems appropriate.</p> <p><b>Date of Compliance</b> July 12, 2013</p>	

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 279	<p>Continued From page 11</p> <p>Resident #4's initial care plan for impaired skin integrity, dated 12/27/12, documented: **Resident has a open areas [sic] of the L (left) buttock and coccyx will be healed by review date." **Resident needs pressure relieving/reducing mattress to protect the skin while in bed." **Resident needs pressure relieving/reducing mattress to protect the skin while up in chair." [NOTE: This approach did not address a specific cushion in Resident #4's chair, but instead identified a mattress. There was no mattress observed in the chair.] **Keep skin clean and dry. Use lotion on dry skin." **Monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration, etc. to MD."</p> <p>NOTE: There were no care plan approaches for staff to cue or assist Resident #4 to reposition or otherwise engage in pressure relief. There were no care plan approaches for staff to prompt Resident #4 for toileting. There were no care plan approaches identifying what kind of pressure relief would be provided in Resident #4's chair.</p> <p>On 6/5/13 at 1:45 PM, the ADON was interviewed regarding Resident #4's care plan for skin integrity and incontinence. The ADON was asked about pressure relief in place for Resident #4 given the facility's assessment of his need for cues, supervision, and physical assistance at the time of admission. The ADON stated Resident #4 was on a frequent toileting plan, which she defined as, "Before and after meals." The ADON stated on 6/4/13 Resident #4 was started on an,</p>	F 279			

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 279	Continued From page 12 "Every 2 hour toileting plan." The ADON was asked if any other pressure relief measures were in place at the time of Resident #4's admission, given he had been admitted to the facility with pressure ulcers to his left buttock and coccyx. The ADON stated, "I'm not sure." The ADON was asked how often staff were to cue and/or assist Resident #4 to stand, walk, or otherwise relieve pressure, based on the assessment of his functional status and cognitive deficits. The ADON stated there was no plan for this because, "He gets up on his own a lot." The ADON was asked about pressure relief in Resident #4's chair, since that need was identified on his care plan. The ADON stated the facility had placed a cushion in Resident #4's chair, "a month or so ago."  On 6/5/13 at 2:10 PM, the Administrator and DON were informed of the concerns with Resident #4's care plan. The facility offered no further information to resolve the concern.  NOTE: Please see F314 as it pertains to Resident #4's pressure ulcers.	F 279			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  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.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280	<b>F280</b> <b>Resident Specific</b> The ID team updated resident # 7's care plan regarding current therapy treatments, light therapy interventions, and quality listening time directives. Resident # 3 has discharged home.  <b>Other Residents</b> The ID team reviewed other residents for necessary care plan updates. Adjustments		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 280	<p>Continued From page 13</p> <p>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, and staff interview, it was determined the facility failed to ensure care plans were revised and updated in a consistent manner. This was true for 2 of 7 sampled residents reviewed (#s 3&amp;7). The failure to keep residents' care plans current with their identified needs created the potential for staff to not provide residents with individualized care and monitoring. Findings include:</p> <p>1. Resident #7 was admitted to the facility on 2/14/12 with diagnoses including psychosis, depressive disorder, bipolar disorder, anxiety state, senile dementia, arthropathy and venous insufficiency.</p> <p>The resident's annual MDS, dated 5/21/13 coded a BMS score of 8, indicating some cognitive impairment, depression, delusions, receives antipsychotic medications 7 days per week, restorative nursing for dressing, grooming, and communication. The prior quarterly MDS, dated 2/26/13, coded the resident was receiving physical therapy 5 days per week.</p>	F 280	<p>were made as indicated. Care plans will be reviewed quarterly and with change of condition.</p> <p><b>Facility Systems</b> The SDC has re-educated licensed nurses, therapists, and the ID team regarding care plan updates and revisions, to include but not limited to specific directives for light therapy and quality listening, resolution of therapy, visual field deficits related to transfer needs, new diagnosis, and discharge plans.</p> <p><b>Monitor</b> The DON and/or designee will review 2 care plans per week for 4 weeks then 1 care plan per week for 12 weeks beginning the week of 7-12-13. The review will be documented on the PI audit tool. Any concerns will be addressed immediately. The PI committee will review the audit results and may adjust the frequency of the monitoring after 16 weeks, as it deems appropriate.</p> <p><b>Date of Compliance</b> July 12, 2013</p>		

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 280	<p>Continued From page 14</p> <p>A 5/20/13 physician's telephone order discontinued the resident's physical therapy. However, the resident's updated care plan, with a revision date of 5/24/13, continued to list the resident was receiving physical therapy 5 days per week.</p> <p>During an interview on 6/6/13, The DON was informed that the current care plan continues to list physical therapy services although the 5/21/13 MDS did code for PT services. No further information was provided.</p> <p>In addition, the resident's current care plan listed a focus area of Signs and Symptoms of depression r/t (related to), "diagnosis of bipolar, depression anxiety, psychosis, paranoia... delusional statements/worries, verbal or physical aggression, hopelessness, negative statements." The intervention list included 11 interventions. Two of the interventions were: * "Light Therapy Q [every] day," initiated 3/12/2012. * "Provide quality listening time and encourage to express feeling in 1:1 visits or in a group," initiated 3/12/2012.</p> <p>The light therapy intervention did not indicate where the therapy would be done, how it would be done, or how long it should last.</p> <p>The provide "quality listening time" intervention gave staff no instructions as to how and when to accomplish this other than 1:1 or in a group.</p> <p>During an interview on 6/6/13 at 3:00 pm, the SW1 explained "Quality listening time" for</p>	F 280			

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>	
(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 280	<p>Continued From page 15</p> <p>Resident #7 is taking time to sit with the resident, talking about what is of interest to her or concerns she is having that day. Staff need to give her plenty of time to respond because she has problems formulating and delivering thoughts. She forgets words. If staff fill in the blank or rush her, she becomes frustrated and will shut down. Also talking too fast or switching quickly from topic to topic is frustrating to the resident. The SW1 stated she would review and revise the care plan to give more instruction for staff on both the quality listening and would check on the light therapy intervention.</p> <p>2. Resident #3 was admitted to the facility on 12/31/12 following a right femur fracture, and a left wrist fracture sustained in the facility from a fall on 2/6/13. She was re-admitted to the facility on 3/2/13 following a GI bleed.</p> <p>Resident #3's re-admission MDS assessment, dated 3/9/13, Resident #3 was cognitively intact, had mild depression, and visual impairment.</p> <p>Resident #3's Visual Function CAA, dated 3/9/13, coded a visual field deficit, diabetic retinopathy, and decreased visual acuity.</p> <p>On 2/11/13, an Occupational Therapy Assistant Weekly Progress Report documented, "Pt showing [increased] anxiety [with] all...ADL...Pt was reluctant to do any type of ROM (range of motion) to [left] UE (upper extremity). Skilled OT is required to assess [and] address anxiety..."</p> <p>On 3/14/13, an MD progress noted documented, "Depressed. Angry about her broken wrist. Not</p>	F 280		

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 280	<p>Continued From page 16</p> <p>interested in trying an anti-depressant. f/u (follow-up) on [left] wrist and [right] femur fracture - being followed by [orthopedic doctor's name]. He wants her in wrist brace for another 4 weeks...PT slow...[Resident #3] discouraged about being at [nursing facility]. [Daughter] has raised the possibility of antidepressants but [Resident #3] adamantly against it...Assessment: situational depression. Plan: discussed options. Cont. to monitor."</p> <p>On 3/27/13, a Nutrition Services Visit Note documented, "Noted by nursing staff that she refuses pain meds, as well as antidepressants..."</p> <p>On 4/15/13, an MD progress note documented. "...situational depression - 'doing fine' (though here [with] friend rather than alone or [with] [daughter] - so may not be completely candid about this issue.)"</p> <p>On 4/17/13, a Health Status Note (identified by the facility dietitian as documentation of an inter-disciplinary discussion) documented, "She has refused foods, refused supplements, refused snacks, and even though she agrees she is depressed, has refused an anti-depressant..." This note was electronically signed by the DON.</p> <p>On 6/5/13 at 9:30 AM, Resident #3 was interviewed. Resident #3 stated she had a fall in the facility on 2/6/13. She stated one of the circumstances leading to the fall was being asked to transfer to the right. Resident #3 stated she could not see out of her right eye, so transferring to that side was difficult for her. Resident #3 stated she was almost ready to discharge from the facility and return to her home to live</p>	F 280		

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 280	<p>Continued From page 17</p> <p>independently at the time of her fall, but her discharge was delayed due to a functional decline related to her fracture. Resident #3 stated she was now uncertain of her discharge plan. She was not certain if she could return home alone again, or would need to move in with her daughter.</p> <p>NOTE: Please see F323 as it pertains to supervision to prevent accidents.</p> <p>Resident #3's care plan documented: *Problem of, "Resident has impaired visual function and wears glasses." However, there were no goals or approaches addressing her visual field deficit, or that it was difficult for her to transfer to the right because of that deficit. *Problem of, "Resident has an actual fall with serious injury r/t Unsteady gait, Poor communication." The goal was listed as, "Resident's right wrist will resolve without complication..." However, Resident #3 had fractured her left wrist. *There were no care plan items addressing either her discharge plan, or her new diagnosis of depression.</p> <p>On 6/5/13 at 9:30 AM, the DON and Administrator were asked for care plan updates in regards to Resident #3's statements she was depressed, and her decision to pursue non-medication options for treatment, as well as for her discharge plan. The DON stated she would look into the discharge plan portion of the care plan. Regarding Resident #3's mood stated, the DON stated, "If she wasn't on an anti-depressant, I doubt there is a care plan." The Administrator and DON were asked about Resident #3's visual field</p>	F 280			

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>	
(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 280	Continued From page 18 deficit. The DON stated the facility became aware of Resident #3's visual field deficit during the investigation into her fall on 2/6/13. When asked if this information was included in the care plan, the DON stated, "I thought if we put her glasses on there (Resident #3's care plan) it would be enough."  On 6/6/13 at 7:15 PM, the Administrator and DON were informed of these findings. The facility offered no further information.	F 280		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview it was determined the facility did not ensure a resident who entered the facility with pressure sores received appropriate services to promote healing, and did not ensure new pressure sores did not develop while the resident was in the facility. This was true for 1 of 6 residents reviewed for pressure sores (Resident # 4). The deficient practice caused harm to Resident #4 when the Stage II pressure sore on his left buttock worsened before healing, then	F 314	<b>F314</b>  <b>Resident Specific</b> The ID team reviewed resident # 4's wound care. The MD notification was documented, current wounds assessed, and care plan interventions are updated.  <b>Other Residents</b> The ID team reviewed other residents for identification of wound types, weekly assessment/documentation, MD notification, and treatment adjustments for healing. Adjustments are made and documented as indicated.  <b>Facility Systems</b> The SDC and DON has re-educate licensed nurses to wound prevention and healing, to include but not limited to correct assessment for wound type, wound terminology, assessment/documentation on admission and weekly, MD notification of wound improvement or lack of improvement, and implementation of resident plans of care. A wound team is developed to validate quality	

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 314	<p>Continued From page 19</p> <p>re-opened, and he developed a Stage II pressure sore on his right buttock. Findings included:</p> <p>Resident #4 was admitted to the facility on 12/17/12 with diagnoses which included dementia with sundowning, infected decubitus ulcers vs. decubitus urinary incontinence, and scrotal ulcers. (NOTE: The facility's admission orders record did not document how many ulcers the resident had on admission, or specific locations of the ulcers.)</p> <p>Documents from [name of acute care hospital] documented:</p> <p>*12/13/12: History and Physical (H&amp;P): "...significant sores and concern for overall worsening of his [Resident #4's] condition...buttocks [with] 2 sores through the skin...area under scrotum red, Erythematous with lesser breakdown...sores - needs pressure offloading...cellulitis in above areas..."</p> <p>*Daily Assessment Inquiry Forms -12/13/12. Pressure Ulcer to sacrum. Stage I, butterfly pattern over sacrum. -12/13/12. Pressure Ulcer to left buttock. 12/14/12, "Buttocks has sores - largest on right cheek, appears stage 2 possibly, wound care RN has assessed." -12/15/12. Multiple Pressure Ulcers to peri-area and buttock. -12/16/12. Pressure Ulcers to scrotum, groin, and buttock, improving. -12/17/12. Pressure Ulcers to scrotum, groin, and buttock, improving.</p> <p>Resident #4's Admission Orders Record, dated 12/17/13, documented, "Vasolex thin layer topical to Buttock, Penis, Groin BID (twice daily).</p>	F 314	<p>wound care implementation for wound prevention and healing.</p> <p><b>Monitor</b> The DON and/or designee will observe residents skin for validation of proper assessment/documentation, MD notification, and care plan implementation for 2 residents per week for 4 weeks then 1 resident per week for 12 weeks beginning the week of 7-12-13. The review will be documented on the PI audit tool. Any concerns will be addressed immediately. The PI committee will review the audit results and may adjust the frequency of the monitoring after 16 weeks, as it deems appropriate.</p> <p><b>Date of Compliance</b> July 12, 2013</p>		

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>	
(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 314	Continued From page 20  Resident #4's Admission Skin Inspection, dated 12/17/12, documented: *Bruising to the right wrist and forearm, and to the left forearm and elbow. *Scabs to the right forearm and right outer leg. *Rash to the coccyx. *Stage II pressure ulcers (PU) to the coccyx measuring 1.5 centimeters (cm) long by (x) 1.5 cm wide x 0.3 cm deep, and to the left buttock 2 cm x .05 cm x 0.3 cm. [NOTE: There was no further documentation regarding the pressure ulcer on Resident #4's coccyx.]  Resident #4's 12/24/12 Admission MDS assessment coded: *BIMS of 1, indicating severely impaired cognitive skills. *Always incontinent of urine, always continent of bowel. *Needed limited physical assistance from one person for bed mobility and hygiene. *Needed extensive physical assistance from one person for toileting. *Needed cues and supervision for ambulation. *Had 2 Stage II pressure areas present on admission, as well as other open lesions and Moisture Associated Skin Damage (MASD). *No turning or repositioning program.  Resident #4's Pressure Ulcer CAA dated 12/24/12 documented, "Care plan will be developed to address and reduce/eliminate risk factors associated with having pressure areas and assist resident in returning to the highest practicable level of function possible."	F 314		

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>	
(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 314	Continued From page 21 Resident #4's 3/18/13 Quarterly MDS assessment coded: *BIMS of 2, indicating severely impaired cognitive skills. *Frequently incontinent of urine, continent of bowel. *Needed cues and supervision for bed mobility and transfers. *Needed extensive physical assistance from one person for toileting. *Needed limited physical assistance from one person for hygiene. *Independent with ambulation. *One unhealed Stage II pressure area present. *No other unhealed open lesions, no MASD. *Turning and repositioning program.  Resident #4's care plan for impaired skin integrity documented: *"Resident has a open areas [sic] of the L (left) buttock and coccyx will be healed by review date." Initiated 12/27/12. *"Resident needs pressure relieving/reducing mattress to protect the skin while up in chair." Initiated 12/17/12. *"Educate ____ /family/caregivers of causative factors and measures to prevent skin injury." Initiated 2/8/13. [NOTE: this item was revised on 2/17/13 with Resident #4's name where the blank space had been.] *"Identify potential causative factors and eliminate where possible." Initiated 2/8/13 *"Keep skin clean and dry. Use lotion on dry skin." Initiated 12/27/12. *"Monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration, etc. to MD." Initiated 12/27/12.	F 314		

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 314	<p>Continued From page 22</p> <p>**"Apply lotion to BLE (bilateral lower extremities) Q (every) shift." Initiated 3/19/13.</p> <p>**"Wash for NS (normal saline) [sic], apply silvasorb to areas, cover with comfeel sacral dressing, change Q 3-4 days and prn (as needed)." Initiated 4/29/13. [NOTE: There is no indication on Resident #4's care plan when this approach was discontinued, however, the order for this treatment was discontinued on 5/29/13, and it was not on Resident #4's current care plan at the time of survey.]</p> <p>**"Apply barrier cream to buttocks Q change/toileting and prn." Initiated 6/4/13. [NOTE: There was no addition to Resident #4's care plan to include a turning and repositioning program, as documented in Resident #4's 3/18/13 MDS.]</p> <p>Resident #4's MD progress notes documented: *1/14/13, "Skin, appears good..." signed by Resident #4's MD. *2/18/13, no mention of the condition of Resident #4's skin signed by the PA for Resident #4's physician. *3/12/13, no mention of the condition of Resident #4's skin, signed by Resident #4's physician. *4/8/13, "...rash and redness on his penis...yeast dermatitis...anti-fungal cream and barrier cream twice a day...", signed by Resident #4's physician. *6/6/13, a letter signed by Resident #4's physician, addressed "To whom it may concern." The letter documented, "As [Resident #4's] primary care provider during his stay at [facility name], I have been appraised at least every two weeks of his condition, particularly regarding the wounds in his gluteal area. I and the nursing staff have all regarded these wounds to be non-pressure wounds. All assessments have lead</p>	F 314			

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 314	<p>Continued From page 23</p> <p>[sic] us to a diagnosis of incontinence dermatitis, which is reflected in my visit notes as well as our numerous attempts at treatments."</p> <p>Resident #4's Weekly Pressure Ulcer reports for the left buttock documented:</p> <p>*12/17/12: 2 cm x 0.5 cm wide x 0.5 cm deep, Stage II.</p> <p>*12/29/12: 1 cm x 1 cm x 0.2 cm, Stage II.</p> <p>*1/1/13 : 1 cm x 1 cm x 0 cm, Stage II.</p> <p>*1/13/13: 1 cm x 1 cm x 0 cm, Stage II.</p> <p>*1/20/13 : 1 cm x 1 cm x 0 cm, Stage II. [NOTE: There was no improvement in Resident #4's PU documented between 1/1/13 and 1/20/13.]</p> <p>*1/27/13: 1 cm x 1 cm x 0.2 cm, Stage II. [NOTE: The PU had been previously documented as having no depth, indicating it was worsening at this point.]</p> <p>*2/13/13: 0.3 cm x 0.4 cm x 0 cm, Stage I. [NOTE: There was no Weekly Pressure Ulcer report for this wound documented between 1/27/13 and 2/13/13. On 2/13/13, the wound was documented to have improved from a Stage II to a Stage I.]</p> <p>*2/20/13: 1 cm x 0.5 cm x 0.1 cm, Stage II. [NOTE: Increased in size and depth from the previous week. The PU was documented to have deteriorated from a Stage I the previous week to a Stage II. No new orders were received until 2/26/13, which were to apply Baza anti-fungal cream to buttock each shift.]</p> <p>*2/27/13: 1 cm x 0.5 cm x 0.1 cm, Stage II.</p> <p>*3/5/13: 0.5 cm x 0.5 cm x 0.1 cm, Stage II.</p> <p>* 3/12/13: 1.2 cm x 0.5 cm x 1 cm, Stage II. [NOTE: Increased in size and depth from the previous week.]</p> <p>*3/22/13: 1 cm long x 1 cm wide. The area for "Depth" was blank. Stage II.</p>	F 314			

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 314	<p>Continued From page 24</p> <p>*3/26/13: 0.5 cm x 0.5 cm x u-4, Unstageable. [NOTE: There was no documentation as to what "u-4" indicated.]</p> <p>*4/9/13: 6 cm x 4 cm x 0.1 cm, Stage II. [NOTE: The wound was documented to have grown by 5.5 cm in length and 3.5 cm in width between 3/26/13 and 4/9/13. The only new order received for skin care during this timeframe was to apply barrier and anti-fungal cream to Resident #4's penis.]</p> <p>*4/16/13: 6 cm x 4 cm x 0.1 cm, Stage II. The form further documented for that week, "Area is excoriated and has deteriorated as has his other buttock due to incontinence." [NOTE: This was the date Resident #4's MAR began to include documentation from the nurse once per shift Resident #4 had been toileted.]</p> <p>*5/1/13: 3 cm x 2 cm x 0.2 cm, Stage II. [NOTE: There was no Weekly Pressure Ulcer report for this wound documented between 4/16/13 and 5/1/13. There were, however, new orders for wound treatment received on 4/24/13.]</p> <p>*5/14/13: 0.2 cm x 0.3 cm x 0.2 cm, Stage II. [NOTE: There was no Weekly Pressure Ulcer report for this wound documented between 5/1/13 and 5/14/13.]</p> <p>*5/21/13: 0 cm x 0 cm x 0 cm, no stage. Shape specified as, "Healed area."</p> <p>*5/28/13: 0.3 cm x 0.2 cm x .02 cm, Stage II. [NOTE: This wound was documented as healed the previous week, but was now documented to be open again.]</p> <p>*6/4/13. 1.0 cm x 0.5 cm x 0.1 cm. Stage II.</p> <p>On 2/3/13, a facility Weekly Pressure Ulcer report documented a Stage II pressure ulcer to the right gluteal fold, measuring 1.2 cm x 1 cm x 0.1 cm. The report documented the date of initial</p>	F 314			

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 314	<p>Continued From page 25</p> <p>observation of this wound was 12/17/12. On 2/10/13, it was documented as 1.0 cm x 1.0 cm x 0.1 cm. There was no documentation of PUs to Resident #4's right gluteal fold before 2/3/13 or after 2/10/13.</p> <p>On 4/23/13, a facility Weekly Pressure Ulcer report documented a Stage II PU to Resident #4's right buttock, measuring 1.3 cm x 2 cm x .01 cm. The date of initial observation of this wound was documented as 12/20/12. [NOTE: There was no facility documentation at the time of admission of PUs or other skin issues to Resident #4's right buttock. There was no facility documentation of a PU to Resident #4's right buttock between his admission on 12/17/12, and the Weekly Pressure Ulcer report on 4/23/13.]</p> <p>The Weekly Pressure Ulcer reports for the PU on Resident #4's right buttock documented:            *5/7/13: 0.3 cm x 0.6 cm x 0.2 cm, Stage II.            *5/15/13: 0.1 cm x 0.2 cm x 0.2 cm, Stage II.            *5/22/13: 0.5 cm x 0.2 cm x 0.2 cm, Stage II.            *5/29/13: 0.3 cm x 0.1 cm x 0.2 cm, Stage II.            *6/4/13: 0 cm x 0 cm x 0 cm, "Wound has healed."</p> <p>Resident #4's Physician's Telephone Orders documented:            *2/26/13: "Baza anti-fungal cream to buttock Q shift."            *4/8/13: "Apply barrier - anti-fungal cream to penis BID (twice daily) topical until inflammation resolved. Dx fungal infection."            *4/16/13: "Place on Q round toileting on MAR for nurse to document completion excoriation per [Nursing Order]."            *4/16/13: "[Change] tx (treatment) to: Apply</p>	F 314			

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 314	<p>Continued From page 26</p> <p>anti-fungal cream, put nystatin powder, cover [with] barrier cream topical TID (three times daily). D/C (discontinue) vasolex."</p> <p>*4/24/13: Physician's Order Request. "We need a D/C order for nystatin [and] barrier cream to buttocks. Now we are using the silvasorb and comfeel." Signed by Resident #4's physician.</p> <p>*4/24/13: Physician's Order Request. "Wound request for buttocks wounds. Cleanse [with] normal saline, apply silvasorb to areas, cover [with] sacral dressing. [Change] Q 3 days and prn." Signed by Resident #4's physician.</p> <p>*5/21/13: "[Change] tx to buttock to Baza clear. Topical TID"</p> <p>*5/29/13: "D/C silvasorb [and] sacral [dressing] to buttock/ Apply barrier cream top[ical] TID to Buttock (Baza clear). Dx Pressure Sore."</p> <p>On 6/3/13 at approximately 2:30 PM, during the initial tour of the facility, Resident #4 was noted to be sitting in a stationary chair in his room.</p> <p>On 6/4/13 at 8:10 AM, Resident # 4 was observed sitting in the same stationary chair in his room, in the same position, until 10:00 AM. At 10:00 AM, he was not in his room or in the bathroom. A blue gel pad was observed in the stationary chair. Resident #4 was observed again in the stationary chair from 10:50 AM until 3:15 PM.</p> <p>On 6/5/13 at 1:30 PM, the surveyor observed Resident #4's wound to his buttocks along with the ADON. The surveyor noted a Stage II pressure ulcer to the medial aspect of the left buttock, half moon shaped with granulation, no drainage. The ADON stated it was measured the day before at 1.0 cm x 0.5 cm. The surveyor also</p>	F 314			

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 314	<p>Continued From page 27</p> <p>observed 2 healed areas to Resident #4's right buttock.</p> <p>On 6/5/13 at 1:45 PM, the ADON was interviewed about Resident #4's skin breakdown. While looking at the computerized skin records with the surveyor, the ADON reported Resident #4 was admitted with his skin issues. She clarified Resident #4 had been admitted with 2 pressure areas, and stated, "but his daughter thinks they are incontinence related." The ADON could not recall exactly where Resident #4's PUs were on admission, but upon reviewing the computerized record stated, "It looks like they were on his coccyx and his left buttock." The ADON stated Resident #4 currently had 1 open pressure area and 1 scabbed over area. She described the open area as "getting semi-closed, then open again."</p> <p>During the interview on 6/5/13 at 1:45 PM, the ADON was asked what measures were in place to reduce skin problems, the ADON stated, "Frequent toileting." When asked what frequent toileting meant, the ADON stated, "Before and after meals, and as of yesterday a 2 hour toileting plan." The ADON was asked what toileting plan had been in place before that. The ADON stated, "He took himself." The ADON was asked what prompted the change in Resident #4's toileting plan the day before. She stated, "During wound rounds yesterday the DON and I were wondering what could make it (Resident #4's wound) better." The ADON was asked about pressure relief for Resident #4 while sitting in his chair. The ADON stated, "We have a pad in his chair." When asked how long the pad had been in Resident #4's chair, the ADON stated, "I'm not sure. Maybe a</p>	F 314			

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>	
(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 314	<p>Continued From page 28</p> <p>month or so." [NOTE: There had been no care plan changes for the cushion in Resident #4's chair since 12/27/12.] The ADON was asked what other treatments or pressure relief had been tried or were in place. The ADON stated the facility had tried a "comfeel" dressing, but it wouldn't stay in place. The ADON reported other dressings had been tried as well, but they would not stay in place either. The ADON was asked if the facility had requested a wound consultation for Resident #4. The ADON stated, "No. He came with orders from the hospital." The ADON was asked how often staff prompted Resident #4 to get up, so as to provide pressure relief. The ADON stated, "He gets up on his own a lot." The ADON stated there was no schedule for staff to ensure Resident #4 had been up.</p> <p>During the ADON interview on 6/5/13 at 1:45 PM, while reviewing Resident #4's computerized record with the surveyor, the ADON stated she was unsure about the documentation indicating PUs had developed on Resident #4's right gluteal fold and Resident #4's right buttock.</p> <p>On 6/6/13 at 11:15 AM, Resident #4's physician was interviewed about Resident #4's PUs, with the DON present. The physician reported he had cared for Resident #4 prior to his admission to the facility. The physician reported prior to admission, Resident #4 had dependent edema and PUs, and overall had improved in the SNF environment. The physician was asked about the facility documentation indicating the PU on Resident #4's left buttock had worsened, then healed, then re-opened. The physician stated, "I think that's a given." The physician stated he had observed the resident to be quite mobile during</p>	F 314		

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>
---	--

(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 314	<p>Continued From page 29</p> <p>his visits, unless there were other concerns. The surveyor informed the physician of the observations from 6/4/13, where Resident #4 sat for almost 2 hours in the morning without moving, and again in the afternoon for 4 1/2 hours without moving. The physician did not respond to the observation.</p> <p>On 6/6/13 at 11:30 AM, the DON was interviewed about Resident #4's PUs documented by the facility on the left buttock, right gluteal fold, and right buttock, as follows:</p> <p>*The DON stated she was not sure the wound to the right gluteal fold had actually been a PU. She reported she was new to the facility at that time, and no wound team was yet in place. The DON referred to the MD dictation dated 6/6/13 which documented the wounds on the gluteal area were non-pressure wounds.</p> <p>*The DON was asked about the worsening of Resident #4's PU to his left buttock, documented by the facility, between 3/26/13 and 4/9/13. The DON stated, "He was more incontinent at that time." When asked how the facility had responded to Resident #4's increased incontinence, the DON stated, "We had the nurse document on the MAR when he was toileted." [NOTE: There was no documentation from the facility that this measure had been implemented until 4/16/13, at least a week after the wound was noted to have worsened. Resident #4's MAR documented "Q round toileting" took place only once per shift (three times daily) beginning 4/16/13.]</p> <p>*The DON reported on 4/24/13 the facility tried covering Resident #4's wounds, but the resident "started tearing them off", so treatments involving covering the wounds were discontinued.</p>	F 314		
-------	---	-------	--	--

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 314	Continued From page 30 *When asked about Resident #4's wound to his right buttock developing, and the wound to his left buttock healing then re-opening, the DON stated, "It was fungal. But once it was documented as pressure, it stays pressure." The DON further stated, "The physician insists it (the PU's) are related to incontinence. When asked if the physician had documented that assessment while treating the wounds, the DON stated, "No." The DON was asked, even if the wounds were related to incontinence, if the facility could show what they had done to improve the wound to the left buttock, to prevent the wound to the right buttock, or to keep the wound to the left buttock from re-opening. The DON answered by referring to the nursing order from 4/16/13 for the licensed nurse to document each shift Resident #4 had been toileted. *The DON also stated the wound to the right buttock was documented by the acute care hospital to have been present prior to admission, therefore could be presumed to have been present when Resident #4 was admitted to the nursing facility. The DON was asked to provide documentation of that wound's presence on the facility admission skin assessment. That documentation could not be ascertained, beyond the DON's supposition the Stage II PU to Resident #4's coccyx noted on the admission assessment may have actually been on his right buttock. The DON was asked for facility documentation monitoring the wound between the time of Resident #4's admission on 12/17/12 and the first notation of a wound to the right buttock noted on a facility Weekly PU report on 4/23/13. The DON stated, "There were clearly 2 PUs present at admission." The surveyor referred again to the facility admission skin assessment,	F 314			

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>	
(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 314	Continued From page 31 which documented Stage II PU's to Resident #4's coccyx and left buttock at the time of admission, but continued documentation on only the wound to the left buttock. The DON stated it was likely an error in knowledge of the person assessing the wounds during that time on how wounds should be measured, and the facility has since implemented a wound team. However, no other explanations were offered.  On 6/6/13 at 7:15 PM, the administrator and DON were informed of the findings. On 6/11/13 BFS received a fax re-iterating the facility's explanation of Resident #4's wounds. However, this information did not resolve the concerns.	F 314		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility did not ensure adequate supervision to prevent accidents. This was true for 1 of 6 residents (Resident #3) sampled for falls. Resident #3 was harmed when she was transferred improperly by facility staff and fell, sustaining a left wrist fracture. Resident #3 experienced a decline in her function as a result	F 323	<b>F323</b>  <b>Resident Specific</b> Resident #3 has discharged home.  <b>Other Residents</b> The ID team reviewed other residents for proper transfers, as well as, residents with recent falls for change in mood status. Adjustments and documentation was made as indicated.  <b>Facility Systems</b> The SDC re-educated nursing staff on transfers, including but not limited to use of gait belts, resident cell phone use or distracting tasks while toileting, communication with resident, attention to visual deficits, and reporting change in behaviors.	

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 323	<p>Continued From page 32</p> <p>of the fracture, delaying her return to her home in the community, and prompting a change in her mood state. Findings included:</p> <p>Facility policy for Patient Mobility - Safety, Release Date 4/28/13, included, for Components of the Saf-Lift program:</p> <p>1. b) Training. g) On-going evaluations. h) Accountability.</p> <p>5. Gait belts are used with patient requiring "hands on" assistance unless contraindicated, for the primary purpose of staff and patient safety. Gait belts are considered part of a direct care staff's uniform.</p> <p>10. Staff training includes, but is not limited to: c.</p> <p>7) Gait belt. As part of the actual training, trainers have the class participants verbally describe and then actually demonstrate/practice their proficiency with each skill.</p> <p>11. Every department has a role in making the ambulation and transfer programs successful. Each department should know what his or her individual responsibilities are: h. Employees 1) Comply with parameters of the Saf-Lift Program.</p> <p>6) Encourage patient participation on Saf-Lift practices through education and communication as appropriate.</p> <p>Resident #3 was admitted to the facility on 12/31/12 for rehabilitation following a fall with a right femur fracture at home. She was readmitted to the facility on 3/2/13 following a brief hospitalization for a gastrointestinal (GI) bleed.</p> <p>Resident #3's Admission MDS assessment, dated 1/7/13, coded: *Minimal cognitive impairment. *No depression.</p>	F 323	<p><b>Monitor</b></p> <p>The SDC and/or designee will observe 3 staff members weekly for 2 weeks, then 2 staff members per week for 2 weeks, then 1 staff member per week for 12 weeks during resident transfers for safety in transfers beginning the week of 7-12-13. The review will be documented on the PI audit tool. Any concerns will be addressed immediately. The PI committee will review the audit results and may adjust the frequency of the monitoring after 16 weeks, as it deems appropriate.</p> <p><b>Date of Compliance</b> July 12, 2013</p>		

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 323	<p>Continued From page 33</p> <ul style="list-style-type: none"> <li>*Extensive assistance from one person required for bed mobility, transfers, and toilet use.</li> <li>*Extensive assistance from one person required for dressing and hygiene.</li> <li>*Limited assistance from one person required for wheelchair mobility.</li> <li>*Ambulation did not occur.</li> <li>*Continent of bowel, occasionally incontinent of urine.</li> </ul> <p>On 2/6/13 at 1:00 PM, a facility Resident Event Report Worksheet documented:</p> <ul style="list-style-type: none"> <li>* Post-Fall Investigation, "While transferring from commode to bed, R (resident) was standing, had already pulled up pants [and] tied them, then R went to sit down before turning to face bottom towards bed. R fell to floor, landing on buttox [sic] [and left] arm while trying to brace self."</li> <li>*Investigation Interviews with CNA #1, "She (Resident #3) was using the commode, then she got up like normal. pulled her pants and tied them like normal. So I moved the commode out from under her then she just sat down without anything behind her [and] fell to the floor."</li> <li>*Investigation Interviews with the licensed nurse, "CNA [name] was transferring R from commode to bed. R on phone with daughter whole time on commode [and] during transfer. No gait belt in use. After R was standing clothes [and] everything ready to get back in bed, commode had already been moved to side so R could turn [and] get into bed easily. R started to sit without looking or feeling if something was behind her [and] fell to floor. Landing on buttox [sic] [and] attempting to brace self from fall with [left] wrist. C/O (complained of) severe pain to [left] wrist, no visible bruising, moderate deformation at wrist. Pain with adduction of hand [and] flexion of</li> </ul>	F 323			

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>	
(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 323	<p>Continued From page 34</p> <p>fingers. Pain to elbow with extension. Oxycodone 5 mg given. Ice applied. Arm immobilized." *PI recommendations, "Gait belt during transfers" and "Phone needs to off [sic] during all transfers." *An attached sheet documented, "IDT (Interdisciplinary Team) review of fall on 02/06/2013. Resident had just been toileted on her commode. She stood up, tied her pants, and the CNA prepared to remove her commode to transfer her back to bed. The resident did not know she had the commode removed, and went to sit back down, falling on to her right arm and buttocks. The CNA was getting ready to sit the resident on the bed and did not have the gait belt on her. Staff counseling provided to be hands on and gait belt with all residents unless they are independent per therapy."</p> <p>A hospital emergency room record for Resident #3, dated 2/6/13 at 2:12 PM, lists a primary diagnosis of, "Fracture of the distal radius. Skin over the site is intact."</p> <p>a. Functional Indicators:</p> <p>Resident #3's nurse's Progress Notes documented: *1/27/13 at 3:50 PM, "Resident is a 1 person assist with transfers and ADLs..." *1/28/13 at 10:00 PM, "Resident is a 1 assist [with] transfers, propels self in w/c (wheelchair)." *1/29/13 at 6:24 PM, "...1 standby assist [with] transfers, propels self in w/c..." *1/30/13 at 6:00 PM, "...1 standby assist [with] transfers, propels self in w/c..." *2/1/13 at 10:00 PM, "...1 standby assist [with] transfers, propels self in w/c..." *2/2/13 at 5:46 PM, "Transfers with 1 assist and 1</p>	F 323		

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 323	Continued From page 35 assist with ADLs." *2/3/13 at 1:19 PM, "Up with assist of 1 with platform walker..." *2/4/13 at 10:00 PM, "...1 standby assist [with] transfers, propels self in w/c..." *2/5/13 at 10:00 PM, "Resident is a 1 standby assist [with] transfers, propels self in w/c..." *2/6/13 at 10:44 PM. "Resident returned to facility from [acute care hospital] via non-emergent ambulance...Brace wrapped in ACE bandage to left arm...One person transfer assist..." *2/7/13 at 10:11 AM, "Resident received fall while transferring in room. Resident was talking on phone at time of fall (ear piece). when [sic] resident was interviewed for fall she stated that she was 'probably' distracted and not paying attention to what was going on. Resident was not wearing a gait belt at time of fall. Resident will now have a gait belt on during all transfers and will be a 2 person transfer at this time d/t fracture. Resident has also agreed to turn phone off during all cares." *2/8/13 at 12:39 PM, "IDT review of fall on 02/06/2013. Resident had just been toileted on her commode. She stood up, tied her pants, and the CNA prepared to remove her commode to transfer her to bed. The resident did not know she (the CNA) had the commode removed, and went to sit back down, falling on her right arm and buttocks. The CNA was getting ready to sit the resident on the bed and did not have the gait belt on her. Staff counseling provided to be hands on and gait belt with all residents unless they are independent per therapy." *2/10/13 at 10:54 AM, "Resident is a 2 person assist with gait belt at this time..." *2/11/13 at 6:12 PM, "Resident is an assist of 2 since fall onto [left] arm...daughter in [at] bedside	F 323			

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>
---	--

(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 323	<p>Continued From page 36</p> <p>all day, pushed resident t/o (throughout) facility..."</p> <p>*2/13/13 at 6:22 PM, "Resident is assist of 2 since fall onto [left] arm. Resident's daughter in a [sic] bedside all day, pushed resident (in wheelchair) t/o facility again today..."</p> <p>*2/14/13 at 9:54 pm, "Two person assist with transfers."</p> <p>*2/15/13 at 8:35 PM, "...up with assist x 2..."</p> <p>*2/16/13 at 5:37 PM, "...assist of 2 since fall onto [left] arm...daughter in a [sic] all day, pushed resident t/o facility again today..."</p> <p>Resident #3's PNs continued to document 2 person assist, and her daughter helping her to propel her wheelchair throughout the facility, until 2/26/13 when Resident #3 was discharged from the nursing facility to the acute care hospital for a Gi bleed.</p> <p>NOTE: For the purposes of assessment, the physical and occupational therapy progress reports use the following functional scores, to describe how much assistance a resident required with a functional activity: NA = Not Addressed 1.0 = Complete Dependence (No contribution from the patient.) 1.7 = Near Total Dependence (Only partial assistance from the patient.) 2.0 = Maximum Assistance, required 75-90% (percent) assistance 2.5 = Moderate - Maximum Assistance, required 50-75% assistance . 3.0 = Moderate Assistance, required 40-50% assistance. 3.5 = Minimal to Moderate Assistance, required 25-40% assistance. 4.0 = Minimal Assistance, required 25% or less</p>	F 323		
-------	--	-------	--	--

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>	
(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 323	<p>Continued From page 37</p> <p>time or effort to complete.</p> <p>4.5 = Contact Guard Assistance (CGA).</p> <p>5.0 = Stand-by Assistance (SBA), no physical assistance beyond set-up, supervision, or cues.</p> <p>6.0 = Modified Independent, no assist, but equipment and extra time.</p> <p>7.0 = Complete Independence, no assistance, no equipment.</p> <p>Resident #3's Physical Therapy (PT) progress notes documented:</p> <p>*Week of 12/31/12 - 1/7/13: Bed mobility score was 3.5, transfer score was 3.5, gait score was 3.0. Goal of rehabilitation was for Resident #3 to reach her prior level of function and return home independently.</p> <p>*Week of 1/7/13 - 1/14/13: Bed mobility 5.0, transfers 4.0, gait 4.5.</p> <p>*Week of 1/14/13 - 1/21/13: Bed mobility 6.0, transfers 5.0-6.0, gait 5.0.</p> <p>*Week of 1/21/13 - 1/28/13: Bed mobility 7.0, transfers 6.0, gait 5.0.</p> <p>*Week of 1/28-13 - 2/4/13: Bed mobility 7.0, transfers 6.0, gait 5.0-6.0.</p> <p>*Week of 2/4/13 - 2/11/13: Bed mobility 4.5-5.0, transfers 2.0-3.0, gait NA. The comparative statement area of the form documented, "Pt (patient) [with] recent fall in room resulting in a fx (fracture) [left] distal radius [and] ulna and immobilized in a splint cast [with] no WB (weight bearing). Pt now [with] TDWB (touch-down weight bearing) [right] LE (lower extremity), NWB (non-weight bearing) [left] UE (upper extremity). End-stage [right] shld (shoulder) OA (osteoarthritis). PT is transferring easier but now requires assist x 2 and is unable to use platform walker." [NOTE: This indicated a measurable functional decline from the previous week.]</p>	F 323		

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 323	<p>Continued From page 38</p> <p>*Week of 2/11/13-2/18/13: Bed mobility 4.5-5.0, transfers 4.0, gait 2-3 steps, 3.0.</p> <p>Resident #3's Occupational Therapy (OT) Progress Reports documented:</p> <p>*Week of 12/31/12 - 1/7/13: Upper Body (UB) dressing 4.5, Lower Body (LB) dressing 2.0, toilet transfer 2.0. Discharge planning goal was listed as, "Home."</p> <p>*Week of 1/7/13 - 1/14/13: UB dressing 3.0, LB dressing 2.5-3.0 with adaptive equipment (AE), toilet transfers 3.0.</p> <p>*Week of 1/14/13 - 1/21/13: UB dressing 5.0-6.0, LB dressing 3.0 with AE, toilet transfers 3.5.</p> <p>*Week of 1/22/13 - 1/28/13: UB dressing 6.0, LB dressing 3.0, toilet transfer 4.0.</p> <p>*Week of 1/28/13 - 2/4-13: UB dressing 6.0, LB dressing 4.5, toileting with commode 4.5-5.0. The comparative statement area of that form documented, "Pt able to progress to CGA/SBA [with] toileting at bedside commode needing [assistance] to hold commode only. Pt able to manage LB garments [and] peri care [with] SBA only due to fair balance at FWW (front-wheeled walker)."</p> <p>*Week of 2/5/13 - 2/11/13: UB dressing 1.7, LB dressing 1.0, toilet with BSC (bedside commode) 1.0. [NOTE: This assessment indicated a measurable functional decline from the previous week.]</p> <p>*Week of 2/11/13-02/18/13: UB dressing 2.0, UB dressing 1.7, toileting with BSC 1.7.</p> <p>*Week of 2/18/13 - 2/25/13: UB dressing 2.5, LB dressing 1.7, toileting with BSC 1.7.</p> <p>Resident #3's Late Loss ADL Flow Sheets documented the following amount of assistance required for toileting, transfers, and bed mobility:</p>	F 323			

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>
---	--

(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 323	<p>Continued From page 39</p> <p>*1/1/13-1/9/13: Extensive assistance to dependent on 2 people.</p> <p>*1/10/13-2/6/13: Extensive assistance of 1 person.</p> <p>*Starting with Evening shift on 2/6/13: Extensive assistance to dependent on 2 people, until 2/26/13.</p> <p>NOTE: On 2/26/13 Resident #3 was discharged from the facility to the acute care hospital for a GI bleed.</p> <p>b. Mood Indicators:</p> <p>On 2/11/13, an Occupational Therapy Assistant Weekly Progress Report documented, "Pt showing [increased] anxiety [with] all...ADL...Pt was reluctant to do any type of ROM (range of motion) to [left] UE (upper extremity). Skilled OT is required to assess [and] address anxiety..."</p> <p>On 3/14/13, an MD progress noted documented, "Depressed. Angry about her broken wrist. Not interested in trying an anti-depressant. f/u (follow-up) on [left] wrist and [right] femur fracture - being followed by [orthopedic doctor's name]. He wants her in wrist brace for another 4 weeks...PT slow...[Resident #3] discouraged about being at [nursing facility]. [Daughter] has raised the possibility of antidepressants but [Resident #3] adamantly against it...Assessment: situational depression. Plan: discussed options. Cont. to monitor."</p> <p>On 3/27/13, a Nutrition Services Visit Note documented, "Noted by nursing staff that she refuses pain meds, as well as antidepressants..."</p>	F 323		
-------	---	-------	--	--

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 323	<p>Continued From page 40</p> <p>On 4/15/13, an MD progress note documented. "...situational depression - 'doing fine' (though here [with] friend rather than alone or [with] [daughter] - so may not be completely candid about this issue.)"</p> <p>On 4/17/13, a Health Status Note (identified by the facility dietician as documentation of an inter-disciplinary discussion) documented, "She has refused foods, refused supplements, refused snacks, and even though she agrees she is depressed, has refused an anti-depressant..." This note was electronically signed by the DON.</p> <p>On 6/4/13 at 9:30 AM, Resident #3 was interviewed. She stated at the time of the fall on 2/6/13, "I was almost ready to go home. Now I don't know when I will be ready to go home. I might have to go live with my daughter. I was done with the commode and the CNA moved it. She did not tell me she was moving it. I can't see out of my right eye, so I couldn't see it had been moved. She should have helped me to stand from the commode, then moved the wheelchair behind me to sit. When I reached back, there was nothing to sit on. She was not helping me, and didn't have one of those belts so she couldn't catch me when I fell. I broke my wrist." Resident #3 held up her left wrist and stated, "Look at it. It will always be that way now." The surveyor observed a round smooth lump under the skin on Resident #3's left wrist, approximately 2" in size. Resident #3 stated she had been talking on her cell phone (via a hands-free ear piece) the whole time, "but she still should have told me she was moving the commode. I could still hear her. I just couldn't see on that side, so when she didn't tell me she moved it I thought it was still there."</p>	F 323		

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 323	<p>Continued From page 41</p> <p>On 6/5/12 at 2:10 PM, the Administrator and DON were interviewed about Resident #3's fall and fractured wrist. The DON stated, "Resident #3 was being transferred to the commode. The CNA stood her (Resident #3) up, moved the commode from behind her, but did not tell (Resident #3) she had moved the commode. She (the CNA) was not using a gait belt. [Resident #3] fell." The Administrator and DON were asked about Resident #3's visual field deficit. The DON stated the facility became aware of Resident #3's visual field deficit during the investigation into her fall. The DON stated Resident #3 was likely distracted during the transfer due to being on her cell phone at the time. The DON was asked if the CNA had recognized Resident #3 may have been distracted by this, and used either extra caution with the transfer, or requested Resident #3 terminate the call until after the transfer was complete. The DON stated, "I don't know." The DON and Administrator were asked about mood state changes for Resident #3 after her fall. The surveyor requested the DON review the information in the OT notes, nutrition notes, and the MD progress notes. The DON stated, "I'll look into it." The DON was asked for care plan updates in regards to Resident #3's statements she was depressed, and her decision to pursue non-medication options for treatment. The DON stated, "If she wasn't on an anti-depressant, I doubt there is a care plan."</p> <p>NOTE: Please see F280 as it pertains to care plan revisions.</p> <p>On 6/6/13 at 4:15 PM, the Administrator was again interviewed about Resident #3's fall. The</p>	F 323			

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>	
(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 323	<p>Continued From page 42</p> <p>Administrator stated the facility provided training to all CNAs regarding gait belt use, both at orientation and on an ongoing basis. The Administrator stated there had been re-training to staff on gait belt use after the event. The Administrator stated the facility's expectation was the CNAs would use gait belts with every transfer of a resident, unless the resident had been assessed as independent with transfers by physical therapy. The Administrator stated the CNA involved with Resident #3's fall was an experienced CNA, and had received the training prior to the incident. The Administrator stated Resident #3 had some responsibility for the fall as well, as she had been on her cell phone with her daughter at the time, resulting in unintentional, unexpected actions on both parties' part. The Administrator stated after the event occurred, the facility recognized right away a problem had occurred, followed their process exactly for such an occurrence, and had followed up with their Quality Assurance process. The Administrator stated, "I don't know what more we could have done to prevent it (the fall) from happening." When asked if the transfer had taken place according to facility policy (i.e., using a gait belt, explaining to the resident what was happening, etc.) the fall may have been prevented, the Administrator re-iterated the CNA in question had been trained to do those things prior to the event, but for some reason had not done them at the time.</p> <p>On 6/6/13 at 7:15 PM, the Administrator and DON were informed of the surveyor's findings.</p> <p>On 6/7/13 at 9:30 AM, the Administrator provided documentation of the "Individual Learning History"</p>	F 323		

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 323	Continued From page 43 for the CNA transferring Resident #3 at the time of her fall. The forms documented the CNA received Saf-Lift training on 10/10/12, completed Annual CNA Competencies, including transfers and gait belt use, on 12/11/12, and a "Read & Sign" Gait Belt Review on 2/14/13. The Administrator also provided copies of the mood interviews associated with Resident #3's most recent MDS, and stated, "According to this, she was not depressed." The facility offered no explanation regarding the assessments of depression from Resident #3's physician, or the progress notes indicating mood state changes from the occupational therapist, nutrition services, or the DON.  Resident #3 was harmed when she was improperly transferred in the facility, resulting in a fall with a left wrist fracture. Because of that fracture, Resident #3 experienced a decline in her functional status, changes in her mood state, and a delay in her ability to return to her home to live independently.  On 6/11/13 BFS received a fax from the facility requesting the citation be re-considered. However, this did not resolve the concern with Resident #3's fall.	F 323			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose	F 329	<b>F329</b>  <b>Resident Specific</b> The ID team reviewed resident # 2. This resident is no longer on anti-coagulant therapy.  <b>Other Residents</b> The ID team reviewed other residents who are currently on anti-coagulant therapy to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 329	<p>Continued From page 44</p> <p>should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure adequate monitoring for the administration of anti-coagulation medication. This was true for 1 of 4 residents (#2) sampled for anti-coagulant medication. This deficient practice had the potential to cause more than minimal harm as Resident #2 was placed at increased risk of bleeding from falls or other injuries while continuing to receive this medication without monitoring. Findings included:</p> <p>Resident #2 was admitted to the facility on 4/12/12 with diagnoses which included CVA and failure to thrive.</p> <p>On 10/29/12, a laboratory report for Resident #2</p>	F 329	<p>validate proper monitoring and documentation. No additional adjustments were indicated.</p> <p><b>Facility Systems</b> The SDC and DON has re-educated licensed staff on anti-coagulant therapy policies and procedures, to include but not limited to lab monitoring.</p> <p><b>Monitor</b> The DON and/or designee will monitor 2 residents on anti-coagulant therapy weekly for 4 weeks, then 1 resident weekly for 12 weeks beginning the week of 7-12-13. Results of monitoring will be documented on the PI audit tool. Any concerns will be addressed immediately. The PI committee will review the audit results and may adjust the frequency of the monitoring after 16 weeks, as it deems appropriate.</p> <p><b>Date of Compliance</b> July 12, 2013</p>		

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 329	<p>Continued From page 45</p> <p>documented Resident #2 was receiving the medication Coumadin, at a dose of 3 mg every other day, alternating with 3.5 mg every other day. PT/INR values on that document were listed as 18.4 and 1.85, respectively. The report documented no change in Coumadin dosage, with PT/INR results to be re-drawn in 1 month (11/29/12). This document was signed by Resident #2's physician.</p> <p>On 12/20/12 at 5:55 AM, a Resident Event Report Worksheet for Resident #2 documented the resident had a fall from bed when her air mattress inflated. Injuries from that fall included bruises to her right shoulder, right thigh, and left knee, as well as a large hematoma about her left eye and forehead. Resident #2 was also noted with skin tears to her right clavicle area and a laceration to her upper lip. Resident #2 was sent to the hospital emergency room for evaluation of her injuries after this fall.</p> <p>On 12/20/12, laboratory results obtained at the hospital emergency room documented PT/INR results of 30.3 and 2.8, respectively.</p> <p>On 1/21/13 at 10:06 AM, Resident #2's Nursing Progress Notes documented, "Late entry IDT follow up. On review of records for [Resident #2] on transfer to the ER found Coumadin monitoring to be missing a draw. On investigation the lab was not drawn on 11/29/2012. The resident did have a lab drawn on transfer to the hospital after a fall and levels were wnf (within normal function). Labs drawn on admit to hospital on 1/16/13 for INR were at 4.0. [Physician's name] aware and resident is said to be within normal lab controls with current draws and levels. Staff education</p>	F 329			

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>	
(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 329	Continued From page 46 provided on procedure to Coumadin management."  [NOTE: Resident #2's Coumadin was discontinued during an acute care hospital stay between 1/16/13 and 1/21/13.]  On 6/6/13 at 3:15 PM, the DON was asked about the missed blood draw for Resident #2's PT/INR. The DON stated she would investigate, but did not think there would be more information available.  On 6/6/13 at 7:15 PM, the Administrator and DON were informed of these findings. However, the facility offered no further information.	F 329		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION  The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility did not ensure the drain for the ice machine behind the 300 hall nurse's station was maintained in safe operating condition. This affected 4 of 10 sampled residents (#'s 5, 6, 7, and 10), and had the potential to affect any resident exposed to the 300 hall environment. This deficient practice had the potential to cause more than minimal harm if the water spilling onto the floor created mold, attracted insects, or caused structural damage to the facility. Findings included:	F 456	<b>F456</b>  <b>Resident Specific</b> The ice machine drain has been corrected and no longer splashes water on the floor.  <b>Other Residents</b> N/A  <b>Facility Systems</b> The SDC and ED has re-educated staff on reporting items in need of repair. Note the area of concern/repair needed on a work order and communicate it to the maintenance director.  <b>Monitor</b> The ED and/or designee will do facility rounds 3 times per week for 4 weeks, then weekly for 12 weeks beginning the week of 7-12-13. Any concerns will be addressed	

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 456	Continued From page 47  On 6/6/13 at 2:50 PM, during the environmental tour with the Maintenance Supervisor (MS) and the Administrator, the surveyor asked if there were ice machines in the facility other than the one in the kitchen. The MS stated there was an ice machine behind the 300 hall nurse's station, used to obtain ice for passing water to the residents. Along with the MS and the Administrator, the surveyor observed the ice machine. There was an elbow-shaped PVC pipe protruding from the back of the ice machine, approximately 3 feet from the floor. Water was dripping from that pipe towards the floor, exposed to the air as it dripped. At floor level, there was a red plastic funnel wedged into a drain at approximately a 45 degree angle, where the wall met the floor. Some of the water from the ice machine was dripping into the funnel, but some was dripping directly onto the floor. There was a damp area on the floor under the ice machine, spreading to the left of the ice machine, approximately 2 feet by 1 foot in size. The area was moist, with a brown slimy substance covering it. There were 2 white towels laying in this area to absorb water from the floor. The towels were wet. The MS stated, "I've been wanting to put in a drain back here."  The Administrator and MS were immediately informed of the surveyor's findings. The facility offered no further information.	F 456	immediately. The PI committee will review the audit results and may adjust the frequency of the monitoring after 16 weeks, as it deems appropriate.  <b>Date of Compliance</b> July 12, 2013		
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS  The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing	F 518	<b>F518</b>  <b>Resident Specific</b> N/A		

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>	
(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 518	<p>Continued From page 48 staff; and carry out unannounced staff drills using those procedures.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and policy review, it was determined the facility did not ensure staff were trained on procedures to respond to emergencies. This was true for 2 of 3 staff interviewed for emergency procedures. This deficient practice had the potential to cause more than minimal harm should an emergency arise and staff not know how to respond. Findings included:</p> <p>Facility policy for fire response documented, "Activate the closest fire alarm..."</p> <p>On 6/4/13 at 3:35 PM, CNA #4 was interviewed about responding to a fire. CNA #4 stated, in the event of a fire, facility staff would, "we would just tell one another about it." CNA #4 was asked if there would be an alarm, or an overhead page, or some other communication mechanism to alert staff. CNA #4 stated, "No. We would just pass the word."</p> <p>On 6/6/13 at 9:00 AM, RN#2 was asked about responding to a power outage. RN #2 was asked how she would obtain power for medical equipment should an outage occur. RN #2 stated, "I don't know." When asked about the red outlets, RN #2 stated, "Oh. I didn't know that's what those were for."</p> <p>On 6/6/13 at 2:50 PM during the environmental tour, the facility Maintenance Supervisor stated in</p>	F 518	<p><b>Other Residents</b> N/A</p> <p><b>Facility Systems</b> The SDC has re-educated staff members on proper procedure and response to emergency situations, including but not limited to fire and emergency power.</p> <p><b>Monitor</b> The SDC, ED, and/or designee will monitor staff knowledge of fire procedure thru staff interview of 3 staff members weekly for 4 weeks and 2 staff members per week for 12 weeks beginning the week of 7-12-13. The review will be documented on the PI audit tool. Any concerns will be addressed immediately. The PI committee will review the audit results and may adjust the frequency of the monitoring after 16 weeks, as it deems appropriate.</p> <p><b>Date of Compliance</b> July 12, 2013</p>	

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

PRINTED: 06/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET</b> <b>MOSCOW, ID 83843</b>		
(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 518	Continued From page 49 the event of a power outage, the emergency generator would power the red outlets in the facility, to be used for powering medical equipment.  On 6/6/13 at 7:15 PM, the Administrator and the DON were informed of these concerns. The facility offered no further information.	F 518			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001500</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS  The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual recertification and complaint investigation survey of your facility.  The surveyors conducting the survey were: Lorraine Hutton, RN, Team Coordinator Nina Sanderson, BSW, LSW	C 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation – Aspen Park does not admit that the deficiencies listed on the State Form 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 125	02.100,03,c,ix Treated with Respect/Dignity  ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Please refer to F 241 as it relates to treating resident's with dignity and respect. Please see F 241 as it pertains to resident dignity.	C 125	C 125  Please refer to F 241 for POC.	
C 147	02.100,05,g Prohibited Uses of Chemical Restraints  g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician. This Rule is not met as evidenced by:	C 147	C 147  Please refer to F 329 for POC.	

**RECEIVED**  
**JUL - 1 2013**  
**FACILITY STANDARDS**

Bureau of Facility Standards

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

*David D. Barnes*

TITLE

*Executive Director*

(X6) DATE

*6-28-13*

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001500</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 147	Continued From page 1 Please see F 329 as it pertains to unnecessary medications.	C 147		
C 778	02.200,03,a PATIENT/RESIDENT CARE  03. Patient/Resident Care.  a. A patient/resident plan of care shall be developed in writing upon admission of the patient/resident, which shall be: This Rule is not met as evidenced by: Please see F 279 as it pertains to development of initial care plans.	C 778	C 778  Please refer to F 279 for POC.	
C 779	02.200,03,a,i Developed from Nursing Assessment  i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Please see F 272 as it pertains to comprehensive assessments.	C 779	C 779  Please refer to F 272 for POC.	
C 782	02.200,03,a,iv Reviewed and Revised  iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F 280 as it relates to reviewing and revising residents' care plans. Please see F 280 as it pertains to care plan revisions.	C 782	C 782  Please refer to F 280 for POC.	
C 789	02.200,03,b,v Prevention of Decubitus	C 789	C 789 Please refer to F 314 for POC.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001500</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 789	Continued From page 2  v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Please see F 314 as it pertains to pressure ulcers.	C 789			
C 790	02.200,03,b,vi Protection from Injury/Accidents  vi. Protection from accident or injury; This Rule is not met as evidenced by: Please see F 323 as it pertains to accident prevention.	C 790	C 790  Please refer to F 323 for POC.		



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

July 1, 2013

David D. Farnes, Administrator  
Kindred Nursing & Rehabilitation - Aspen Park  
420 Rowe Street  
Moscow, ID 83843

Provider #: 135093

Dear Mr. Farnes:

On **June 7, 2013**, a Complaint Investigation survey was conducted at Kindred Nursing & Rehabilitation - Aspen Park. Lorraine Hutton, R.N. and Nina Sanderson, L.S.W. conducted the complaint investigation. This complaint was investigated in conjunction with the annual Recertification and State Licensure survey conducted the week of June 3 - 7, 2013.

During the investigation, the following documents were reviewed:

- The records of eighteen residents, including the identified resident's medical record dated October 25, 2012, thru December 19, 2012. The discharge summary from the identified resident's October 25, 2012, discharge and his December 19, 2012, hospital admission were also reviewed.
- Incident and Accident reports and investigations for October 2012 thru December 2012.
- Grievance files and Resident Council minutes for October 25, 2012, through Jan 1, 2013.

In addition to the review of the above items, multiple staff interviews were conducted; including the Administrator, the Director of Nursing Services (DNS), Assistant Director of Nursing Services (ADNS), direct care staff, licensed nursing staff and physical therapy staff who worked with the resident.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00005868**

**ALLEGATION #1:**

The complainant stated the identified resident was admitted to the facility on approximately October 25, 2012, because he was having a hard time with mobility. The resident did not improve or decline for about two weeks after being admitted to the long term care facility. He then became confused and did not understand what the physical therapist at the facility wanted him to do. The physical therapist at the facility stopped the resident's therapy.

**FINDINGS:**

During the investigation, it was determined that the identified resident was admitted to the facility on October 25, 2012. Prior to his admission to the facility, the transferring hospital documented intermittent episodes of confused speech and disorientation. The resident was at a high fall risk with many attempts to leave his bed, and he was unsteady on his feet. The hospital placed a bed alarm on the resident for his safety. A physician discharge note dated October 24, 2012, documented "Wife believes he is a little more confused today. His cognition has been slightly worse since (starting) Butrane (pain patch)... Urine culture - Staph coag negative (greater than) 100,000... Brain tumor...? (Question) UTI (urinary tract infection) with poor bladder emptying... Start Cephalexin 500 TID (three times per day) for staph coag negative."

A nursing note on the October 25, 2012, transfer sheet documented "Patient needs constant instructions with mobility. PT (patient) follows directions, but at times seems unable to make simple movements without instructions on what to do next."

Physical Therapy notes and Occupational Therapy notes both documented the therapists worked intermittently with the resident until November 21, 2012, when it was determined that he could not participate in those programs due to increased confusion and inability to follow instructions.

Nursing notes and physician progress notes documented the facility became quite concerned with the resident's increasing confusion, multiple attempts to get out of bed and eventually physical aggression towards staff. Nursing notes documented thirteen contacts with the resident's physician and/or on call staff between November 20, 2012, and December 19, 2012. Frequent order changes were received, including discontinuing the Butrane patch, ordering labs and increasing the Ativan. The resident was sent for a CAT scan on November 28, 2012, to determine if his tumors were growing and causing the increased confusion and agitation. The CAT scan did not show further tumor growth.

The resident's hallucinations, behaviors and falls continued to increase despite redirection, distraction, attempt to increase activities, one on one (plus) staffing, use of a Broda chair and

David D. Farnes, Administrator

July 1, 2013

Page 3 of 5

increased use of Ativan for anxiety. During this time, facility staff documented the frequency of the resident's incontinent episodes as two to three episodes per shift. Licensed nursing staff continually monitored the resident for increased pain, which the resident usually denied. Based on his vital signs, absence of complaints of pain, absence of frequency of incontinence and no documented blood in or odor to the urine, the identified resident did not show overt signs and symptoms of a urinary tract infection between October 25, 2012, and December 19, 2012.

On December 16, 2012, the physician ordered a urine analysis with culture and sensitivity (if indicated) because of a peak in the resident's behaviors. The results of the UA were non-conclusive showing multiple bacteria, which could be from contamination. The physician also ordered PRN (as needed) Haldol and Klonopin for the resident's excessive aggressive behaviors. The resident weighed approximately 300 pounds and posed a risk to himself and others. At this time, the facility sought a psychological evaluation. The physician and facility were told that the resident would have to be transferred out of town for the evaluation, as no services were available locally. On December 19, 2012, the resident was transferred to a hospital with a psychiatric facility.

No deficient practice was found related to facility practice and the resident's decline in condition. The facility was in frequent contact with the resident's physician, the interdisciplinary team met frequently regarding the resident and the facility made a responsible attempt to try lesser interventions (such as one to one staffing) prior to medicating the resident with behaviors medications.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

The complainant stated the identified resident was put in a Broda chair because he was falling a couple of times per day. The facility reported there were no injuries from the falls.

#### FINDINGS:

On November 20, 2012, the resident's wife signed consent for the use of the Broda chair. Despite movement alarms, line of sight supervision and then one to one staffing; the resident consistently demonstrated poor safety awareness, frequently impulsively stood and had multiple falls throughout the week. The facility implemented the Broda chair to help decrease the resident's ability to stand impulsively.

No deficient practice was found because the facility implemented less restrictive interventions to prevent falls before they chose the more restrictive Broda chair.

David D. Farnes, Administrator  
July 1, 2013  
Page 4 of 5

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated the resident started to hallucinate. Prior to the hallucinations, the facility had not placed the resident on any new medication. The facility placed the resident on Haldol and two other medications after he began hallucinating and became combative.

FINDINGS:

During the investigation, it was determined the facility acted responsibly in implementing many other measures to help with the resident's behavior before they started to the use of Haldol and Klonopin.

No deficient practice was found because the resident put himself in physical danger for injury related to multiple falls and put staff at great risk because of his aggressive and assaultive behavior.

The Haldol and Klonopin were ordered as an emergency measure and first administered on December 16, 2013. The resident was transferred for psychological evaluation within three days. The resident would have been transferred prior to this, but it was difficult to find a placement for him.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated the identified resident began voiding frequently (at least two times per hour,) and the urine "reeked." The complainant stated the aides were told about the urine, but they did nothing. The complainant stated the facility did not keep track of the resident's voiding. A few days later, the facility contacted family and stated the resident needed to be admitted to the "psych unit." The resident was admitted to the hospital around December 17 or 18, 2012. The resident was there about two weeks and discharged to another long term care facility around January 2, 2013. The resident's condition has really improved since his admission to the other facility, and he is now walking.

The caller stated neither the facility nor the hospital told the family about any medical problems the resident had. However, a nurse from the other facility went to the hospital and read the resident's information. The nurse from the other facility told the family the resident had been

David D. Farnes, Administrator  
July 1, 2013  
Page 5 of 5

"very sick" with a bladder infection and dehydration, and the infection went into the resident's lungs and then into his blood stream.

FINDINGS:

During November and December 2012, facility staff documented the frequency of the resident's incontinent episodes as two to three episodes per shift. As stated previously, based on his vital signs, absence of complaints of pain, absence of frequency of incontinence and no documented blood in or odor to the urine the identified resident did not show overt signs and symptoms of a urinary tract infection between October 25, 2012, and December 19, 2012. On December 16, 2012, the physician ordered a urine analysis with culture and sensitivity (if indicated) because of a peak in the resident's behaviors. The results of the UA (Urine Analysis) were inconclusive showing multiple bacteria, which could be from a contaminated specimen. On December 19, 2012, the resident was transferred to a hospital with a psychiatric facility.

No deficient practice was found related to the facility not recognizing or treating a urinary tract infection.

While at the facility, the resident did not have overt signs and symptoms of a urinary tract infection. The Emergency Room physician documented on December 19, 2012, that the resident was afebrile with no report of fever, chills or blood in the urine, and the resident's blood work was normal. The only sign of a urinary tract infection was pyuria, which was found when the resident was catheterized and a microscopic examination of the urine was done.

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,  


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

LKK/dmj