



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7012 3050 0001 2128 3474

July 24, 2014

Todd "Shane" Bell, Administrator
Kindred Nursing & Rehabilitation-- Nampa
404 North Horton Street
Nampa, ID 83651-6541

Provider #: 135019

Dear Mr. Bell:

On **July 11, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Kindred Nursing & Rehabilitation - Nampa by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 6, 2014**. Failure to submit an acceptable PoC by **August 6, 2014**, may result in the imposition of civil monetary penalties by **August 25, 2014**.

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

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title who will do the monitoring.
 - * It is important that the individual doing the monitoring have the appropriate experience and qualifications for the task.
 - * The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3.
 - * A plan for "random" audits will not be accepted.
 - * Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- Include dates when corrective action will be completed in column (X5).

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **August 8, 2014 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **August 8, 2014**. A change in the seriousness of the deficiencies on **August 8, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 8, 2014** includes the following:

Denial of payment for new admissions effective **October 11, 2014**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 11, 2015**, 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, they will provide you with a separate formal notification of that determination.

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional

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Office or the State Medicaid Agency beginning on **July 11, 2014** 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:

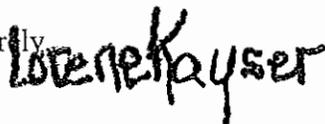
- BFS Letters (06/30/11)

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

This request must be received by **August 6, 2014**. If your request for informal dispute resolution is received after **August 6, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,



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

LK/lj
Enclosures

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

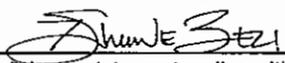
PRINTED: 11/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/11/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - NAMPA	STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Lauren Hoard, RN, BSN, Team Coordinator Nina Sanderson, BSW, LSW Linda Kelly, RN Linda Hukill-Neil, RN</p> <p>The survey team entered the facility on July 7, 2014 and exited on July 11, 2014.</p> <p>Findings in this report reflect changes made through the IDR process.</p> <p>Survey Definitions: ADL = Activities of Daily Living AIT = Administrator in Training BID = Twice a day BIMS = Brief Interview for Mental Status CHF = Congestive Heart Failure CNA = Certified Nurse Aide COPD = Chronic Obstructive Pulmonary Disease CP = Care plan CVA = Cerebrovascular Accident DON/DNS = Director of Nursing Services FSI = Fall Scene Investigation HOB = Head of bed HTN = Hypertension LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment POA = Power of Attorney PRN = As Needed RD = Registered Dietitian R/T = Related to</p>	F 000	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation - Nampa does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p style="text-align: right;">RECEIVED NOV 21 2014 FACILITY STANDARDS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE EXECUTIVE DIRECTOR	(X6) DATE 08/05/2014
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 S/SX, S/S = Signs and symptoms TAR = Treatment Administration Record TID = Three times per day	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure a resident was safe to self-administer medications. This was true for 1 of 1 residents (Resident # 12) sampled for self-administration of medication. The deficient practice had the potential to cause harm if a resident suffered adverse effects if their medications were not taken timely or correctly. Findings included: Resident #12 was admitted to the facility on 11/30/13 with multiple diagnoses which included rheumatoid arthritis and CHF. Resident #12's most recent quarterly MDS assessment coded the resident was cognitively intact, and was independent after set-up to consume food and fluids. Self-Administration of Medication forms in Resident #12's record documented: *3/8/14, the resident was approved to administer eye drops, creams, and ointments without	F 176	F 176 Resident Specific Resident #12 self medication assessment was reviewed. Resident continues to be deemed unsafe to administer her own meds. Medication will not be left at bedside but given by licensed nurse. Other Residents Clinical management team made rounds to validate medications identified in resident rooms corresponds with self medication assessments and physician orders. No additional adjustments were indicated. Facility System Staff Development Coordinator (SDC)/ Director of Nurses (DNS) has educated the licensed nursing staff regarding self medication policy, to include but not limited to, the need for a documented assessment upon initiation of self medication, licensed nurse documentation requirements, and the potential harm for unsecured medications at the bedside. Monitor The SDC and/or designee will make room rounds to validate medications are not at bedside for those without orders on two units each week for 4 weeks, then one unit weekly for 8 weeks The audit will be documented on the Performance Improvement (PI) monitor beginning the	8/8/14

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F 176	<p>Continued From page 2 supervision or problems. *3/13/14, the resident was no longer approved to self-administer medications. The rationale for this change was documented as, "Resident with inconsistent cognitive status."</p> <p>On 7/7/14 at 9:30 AM, during the initial tour of the facility, Resident #12 was observed to be sitting in her wheelchair in her room, unattended, in front of her over bed table. The over bed table contained a banana, a plastic bottle of milk, and a small white paper container with two white caplets in it. With the surveyor present, the resident stated, "I just went to get some milk to take my pills." The resident then took the two caplets from the paper container, placed them in her mouth, and swallowed them with a drink of milk. The surveyor asked the resident what the pills were, and the resident stated, "Those are my Tylenol. But I can't take them without milk."</p> <p>On 7/7/14 at approximately 10:00 AM, RN #1 was asked about Resident #12 taking medications unsupervised. RN #1 stated, "I think she was approved for creams and eye drops and that kind of thing, but I don't think she was assessed for pills by herself. Usually she's pretty content to wait for the nurse to bring them."</p> <p>On 7/10/14 at 2:35 PM, the DNS was asked about Resident #12 administering her own medications. The DNS stated, "No, it's not OK for her to have pills. We heard about this, and went and talked to the nurse. The nurse says she didn't leave the pills there, and uses a plastic cup not a paper one. She (the resident) does have an order for Tylenol, and what you described sounds like the Tylenol we carry. We're investigating it further."</p>	F 176	<p>week of August 8. Any concerns will be addressed immediately and discussed with the Interdisciplinary (ID) team as indicated. The PI committee will review after 90 days and may adjust the frequency of monitoring, as it deems appropriate.</p> <p>Date of Compliance August 8, 2014</p>		

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F 176	Continued From page 3	F 176			
F 280 SS=D	<p>On 7/10/14 at 4:45 PM, the Administrator, DNS, and Nurse Consultant were informed of the surveyors findings. The facility offered no further information.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident/staff interviews, it was determined the facility failed to review and/or revise residents' care plans in a timely manner after changes in the residents' status occurred. This was true for 2 of 13 (#s 2 & 6) sampled residents. This failure</p>	F 280	<p>F 280</p> <p>Resident Specific Resident #2 and #6 have been discharged from the center.</p> <p>Other Residents The ID team reviewed other resident care plans and adjusted care plan accuracy focused on dialysis interventions, diet orders, and catheter use.</p> <p>Facility Systems Resident care plans are established upon admission, reviewed quarterly, and updated periodically with resident changes. The DNS/SDC has re-educated license nurse staff regarding care plan updates, to include but not limited to, dialysis interventions, diet order changes, and catheter use. Morning clinical meeting will include validation of care plan updates with changes. Ongoing review will occur with quarterly care conferences.</p> <p>Monitor The DNS and/or designee will review new orders 5 times per week and audit two care plans per week for 8 weeks to validate accuracy and timely revisions. The audit will be documented on the PI monitor beginning the week of August 8. Any concerns will be addressed immediately and</p>	8/8/14	

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F 280	<p>Continued From page 4 created the potential for harm if residents did not receive appropriate care due to the lack of direction in the care plan. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 5/30/14 with multiple diagnoses including end stage renal disease, inoperable right hip fracture, left toe fracture, chronic obstructive airway disease, and congestive heart failure.</p> <p>The resident's 6/5/14 admit MDS documented under special treatments that the resident was receiving dialysis.</p> <p>Resident #2's Care Plan listed the following focus areas: * Dialysis related to End Stage Renal Failure and the interventions initiated on 5/31/14 were documented "...has AV fistula...Monitor access site upon return from dialysis...Check complete dialysis communication log record on return from dialysis..." *, Skin integrity related to pressure ulcers to coccyx and right buttock... skin tear on left elbow...skin tear on the left forearm (LFA) on 6/6/14. Interventions initiated on 6/1/14 and revised on 6/6/14 documented, "...protective sleeves or geri gloves and elbow protectors to BUE [bilateral upper extremiteis]" and interventions initiated on 6/6/14 documented, "Treatment to LFA skin tear per MD order. [P]protective sleeves to bilateral arms, on in am, off at hs [at night]..."</p> <p>The resident's July 2014 Physician Recapitulation Orders documented "...1500CC [cubic centimeters] Fluid Restriction Daily...Hemo-Dialysis @ [at local dialysis center] M [Monday]-W [Wednesday] -F [Friday] Shut: [sic</p>	F 280	<p>discussed with the ID team as indicated. The PI committee will review after 90 days and may adjust the frequency of monitoring, as it deems appropriate.</p> <p>Date of Compliance August 8, 2014</p>	

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F 280	<p>Continued From page 5</p> <p>Shunt] Lt [left] Arm..." and "...Cleanse S/T [skin tear] to LFA with N/S [normal saline] and apply non-adherent prn [as needed] Monitor Daily..."</p> <p>Resident #2's 5/31/14 Physician Wound Order documented, "...Apply protective sleeves to arms (gerisleeves or elbow protectors)..."</p> <p>The July 2014 resident's wound TAR (treatment administration record) documented, "...Apply protective sleeves to arms (gerisleeves or elbow protectors)..." This record reflected staff initials on 7/1 through 7/9/14.</p> <p>On 6/9/14 Dialysis Communication Record for Resident #2 contained a note from the Dialysis Center under the special instructions "L [left] AVF [arteriovenous fistula] *Do Not apply any elastic stocking on dialysis arm it created huge edema-No sticks, BP [blood pressure], or pressure on Dialysis Arm."</p> <p>On 7/10/14 at 8:00 AM, Resident #2 was observed in her room, in a wheelchair dressed in a short sleeve white T-shirt. At 9:10 AM, the Resident was observed in the therapy room dressed in a short sleeve white T-shirt and no presence of protective sleeves, gerisleeves, or elbow protectors. Resident #2 had been observed on numerous occasions in the 3 days prior to be wearing a long sleeve shirt.</p> <p>On 7/10/14 at 9:50 AM, LN #9 was interviewed regarding the protective sleeves and said they had been discontinued that morning. LN #9 stated, "Care Plan has been altered this morning to take off the tube grips. The dialysis center had sent a message back that they were too much compression. I was told this by the night nurse</p>	F 280		

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F 280	<p>Continued From page 6</p> <p>this morning." The 6/9/14 Dialysis Communication Record was shown to LN #9 and she acknowledged the date and the note from dialysis and said that she was just made aware of this by the night nurse.</p> <p>On 7/10/14 at 10:45 AM the DNS, along with the Nurse Consultant, was interviewed regarding the Dialysis Communication Record and the process for implementation of special instructions received from the Dialysis Center. The DNS stated regarding the sleeve protectors, "That's just to protect her skin and I do not see that on the Care Plan." The DNS acknowledged the Care Plan had been changed as of 7/10/14 and the special instructions from Dialysis Center should have been on the care plan.</p> <p>On 7/10/14 at 4:00 PM, Resident #2 was interviewed regarding her sleeve protectors. The resident was in her room with a long sleeve plaid shirt on and the sleeves rolled up to just below the elbow. Resident stated, "I was told I need to wear long sleeves by the nurse. The nurse told me the state requires that and I don't know why. I was wearing these elastic wraps until just a few weeks ago and the dialysis nurse told me not to anymore. They were too tight. I did like them and with my skin getting so thin, I felt they protected my arms." The Resident showed the surveyor her tube elastic wraps she had stored in her night stand and said she would not be wearing them.</p> <p>2. Resident #6 was admitted to the facility on 6/2/14, had a fall with a right hip fracture on 6/9/14 and left the facility for surgical intervention and was readmitted on 6/13/14. Resident #6 had multiple diagnoses including right hip fracture, abscess of anal and rectal region, dysphagia,</p>	F 280		

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F 280	<p>Continued From page 7 peripheral vascular disease, and hypertension.</p> <p>a. The resident's 6/2/14 Admission Physician's Orders documented, "...Diet Order:Regular; Texture:Mechanical Soft; Liquids:Regular..."</p> <p>The resident's 6/13/14 Admission Physician's Orders and July 2014 Physician Recapitulation Orders documented, "...Diet:Regular; Texture:Regular; Liquids:Regular..."</p> <p>Resident #6's current Care Plan listed the focus as: * Swallowing impaired related to dysphagia and interventions initiated on 6/4/14 were documented "...diet: mechanical soft..liquids as follows: thin..."</p> <p>On 7/8/14 at 12:20 PM, Resident #6 was observed in her room seated in her wheelchair and eating lunch with a diet card in front of her that read regular diet, regular liquid, and small proportions.</p> <p>b. The resident's 6/27/14 Physician Order documented, "...Pt able to void after removing foley...timed voids every 3-4 hours. Remind pt to void..."</p> <p>The CAA dated 6/26/14 triggered for urinary incontinence and indwelling catheter related to restricted mobility included the resident's comments that she sometimes forgets that the tube is there and has bladder retention.</p> <p>Nursing Progress Note dated 6/27/13 at 13:20 (1:20 PM) documented "Pt [patient] out for f/u [follow up] with urologist...Pt's catheter was removed by urologist and pt was able to void after foley removal. MD order for timed voids q [every]</p>	F 280		

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F 280	Continued From page 8 3-4 hrs [hours], remind pt to void..." Resident #6's Bladder Status Evaluation dated 6/30/14 documented the bladder voiding pattern had been completed and resident was incontinent but did toilet and the appropriate bladder rehabilitation/retraining or scheduled toileting program would be, "prompted voiding." Resident #6's current Care Plan listed the focus as: * Indwelling catheter related to urinary retention and interventions initiated on 6/26/14 were documented "...catheter bag...F/C [foley catheter] care Q [every] shift..." On 7/7/14 at 2:20 PM, Resident #6 was observed in her room on her bed. There was no foley catheter seen. When the resident was asked about the foley catheter she stated, "They removed it a couple of days ago and I use the bedside commode."	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to perform after	F 309	F 309 Resident Specific Resident #2 has discharged from the center. Other Residents No other residents are currently receiving dialysis. Facility Systems SDC has re-educated nursing staff regarding documentation and communication for dialysis residents, to include but not limited to completion of the dialysis log vital signs, daily shunt site care, post dialysis shunt site checks, and completion of the	8/8/14	

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F 309	<p>Continued From page 9</p> <p>care for dialysis, monitor a resident's dialysis access site, and ensure communication between the facility and dialysis center was complete. This was true for 1 of 13 (#2) sampled residents. This deficient practice had the potential to cause more than minimal harm if the resident failed to receive appropriate dialysis treatment. Findings included:</p> <p>Resident #2 was admitted to the facility on 5/30/2014 with multiple diagnoses including end stage renal disease, inoperable right hip fracture, left toe fracture, chronic obstructive airway disease, and congestive heart failure.</p> <p>The resident's 6/5/14 admit MDS documented under special treatments that the resident was receiving oxygen and dialysis.</p> <p>The July 2014 Physician recapitulation orders documented "...1500CC [cubic centimeters] Fluid Restriction Daily...Hemo-Dialysis @ [at] local dialysis center [the name] M [Monday]-W [Wednesday]-F [Friday] Shut: [sic Shunt] Lt [left] Arm..."</p> <p>Resident #2's Care Plan listed the focus as Dialysis related to End Stage Renal Failure and the interventions initiated on 5/31/14 documented, "...Palpate gently over area with fingertips or palm of hand to feel for bruit or thrill. Auscultate over fistula with stethoscope to detect bruit. Assess for signs of infection, bleeding or sensation impairment around fistula...Check complete dialysis communication log record on return from dialysis appointments ...Coordinate resident's care in collaboration with dialysis center...Monitor access site upon return from dialysis...Obtain vital signs and weight per protocol...Notify dialysis unit and physician if bruit</p>	F 309	<p>communication tool sent to the dialysis treatment center to include nurses' signature and date.</p> <p>Monitor The DNS/SDC, and/or designee will audit dialysis logs and communication tools three times weekly for each dialysis resident for 4 weeks when admitted, then once weekly for 8 weeks. Audits will be documented on the PI monitor when a dialysis patient is present in the center. Any concerns will be addressed immediately and discussed with the ID team as indicated. The PI committee will review after 90 days and may adjust the frequency of monitoring, as it deems appropriate.</p> <p>Date of Compliance August 8, 2014</p>		

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F 309	<p>Continued From page 10 and thrill is absent..."</p> <p>The facility's Policy and Procedure for Dialysis listed the monitoring information needed for their residents. The facility was to communicate resident information on the day of dialysis pertinent to receiving therapy with the Dialysis Communication Record. The Dialysis Log was to record, monitor and identify changes in resident condition following a dialysis session and to record daily access site care.</p> <p>The Dialysis Log instructions for use were listed as:</p> <ul style="list-style-type: none"> * "...Check (4) the days that the resident has dialysis. * Check (4) the type of access site. * Complete and document vital signs. * Record resident weight. * Initial completion of daily site care. * Observe Atrial Venous Fistula site: a. Bruit or thrill present. * Observe the access site for signs and symptoms of infection. * After the dialysis session check shunt site every hour for 6 hours and document if symptoms (bleeding, pain, redness, swelling) are present or not." <p>The Dialysis Communication Record is completed by the facility prior to dialysis and goes with the resident to dialysis. The Dialysis Center is to complete their portion and any special instructions and the form returns to the facility with the resident.</p> <p>The resident's June 2014 Dialysis Log is missing vital sign information on 6/2, 6/6, 6/9, 6/20, 6/25, and 6/30/14.</p>	F 309			

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F 309	<p>Continued From page 11</p> <p>Resident #2's daily site care and bruit/thrill are not documented on the June and July 2014 Dialysis Log as being done on 17 different days for June 2014 and 4 different days for July 2014.</p> <p>The resident's post dialysis shunt site checks every hour for 6 hours were not documented on June 2014 Dialysis Log as being done on 6/2, 6/27, and 6/30/14.</p> <p>Resident #2's Dialysis Communication Record documentations were not entirely completed (missing access site monitoring, weight, licensed nurse signature, and/or date) on 7 different dialysis treatment days.</p> <p>On 7/10/14 at 10:45 AM the DNS, along with the Nurse Consultant, was interviewed regarding the facility's dialysis process. The DNS said the Facility's Policy and Procedures for Dialysis covered the before and after process. The DNS was asked about the documentation for daily access site care and she stated, "Daily site care is on the log." It was pointed out to her that it was only documented on the days Resident #2 had went to dialysis. DNS acknowledged that it was not documented and possibly not done. The DNS acknowledged the after dialysis care was not documented on several occasions. The DNS was asked about the Dialysis Communication Record and the forms missing information that the Nursing Center was to have completed. The DNS stated, "They should be signing and dating them." DNS acknowledged that several had not been completed entirely and the dialysis center would not have access to their records.</p> <p>On 7/10/14 at 4:30 PM, the Administrator and the</p>	F 309		

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F 309	Continued From page 12 DNS were informed of the issue. The facility did not provide any additional documentation to resolve the issue.	F 309			
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to provide necessary care and services for a resident who needed assistance at meals, and timely assistance for a resident to use the bathroom. This was true for 1 of 9 residents (#8) sampled for ADL assistance. The deficient practice had the potential to cause more than minimal harm if the resident suffered hunger or embarrassment when not receiving assistance as required. Findings included: Resident #8 was admitted to the facility on 5/23/10 with multiple diagnoses which included CVA with right-sided hemiparesis, aphasia, and HTN. Resident #8's most recent significant change of condition MDS assessment, dated 5/15/14, coded: *BIMS of 14, indicating the resident was cognitively intact; *Supervision after set-up for eating; *Continent of bowel and bladder; and *Extensive assistance of 1 for toilet use.	F 311	F 311 Resident Specific Resident #8 has had a change of condition. A physician orders was received for occupational therapy to reassess for self eating assistance and cueing needs. Resident care plan was adjusted as indicated for self eating and toileting needs prior to meal service. Other Residents The ID team reviewed other residents requiring assistance and/or cueing during meal times. Care plans were adjusted as indicated. Dining room observation show residents receiving cueing and assistance as needed. Facility Systems DNS/SDC has re-educated nursing staff regarding implementation and monitoring of patient needs and care plan interventions before and during meals, to include but not limited to call light use when seeking other staff assist, quality time for cueing, hands on assistance when indicated, potential communication with physician regarding referral to occupational therapy, and toileting assist patterns Identified to avoid need for toileting during meals. Monitor The DNS, and/or designee will monitor pre-meal care plan intervention implementation, cueing, and hands on assistance during	8/8/14	

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F 311	Continued From page 13 a. Resident #8's care plan documented, under the focus area of "...at risk for malnutrition...", the intervention of, "Resident requires a RNA Dining program to require greater than or equal to 15 minutes of RNA time [every day] to physically cue or verbally cue the resident. Cue to pick up fork and bring to mouth. Assist as necessary. Cue to drink fluids, place drink in hand. Provide hand over hand guidance for meal intake as necessary..." Date initiated for this intervention was documented as 4/30/14, revised on 5/28/14. It was not clear which parts of the intervention were implemented on 4/30/14, nor which were revised on 5/28/14. There were no further care plan interventions which documented providing assistance for the resident at meal time. b. On 7/8/14, between 8:10 AM and 8:52 AM, Resident #8 was observed at breakfast: *8:10 AM, Resident #8 was served a whole hard-boiled egg in a small bowl. The bowl had been placed on a lipped plate with biscuits and gravy. A bowl of cream of wheat was also served, but was not placed within the resident's reach. The resident continued to sit at the table without initiating the consumption of her meal. *8:15 AM - 8:16 AM, CNA #15 approached Resident #8 at the table and asked the resident if she needed help. The resident did not respond. CNA #15 picked up Resident #8's fork, chopped the hard-boiled egg, and left the table. The resident still had not responded to the inquiry of needing help. CNA #15 did not cue or assist the resident further, nor wait to see if the resident was able to feed herself at that meal. *8:16 AM, Resident #8 began using her fork to slowly take a bite of her biscuits and gravy. She then took a bite of the hard boiled egg. Once	F 311	meals in the assisted dining room two times per week for 4 weeks, then once weekly for 8 weeks. Audits will be documented on the PI monitor beginning the week of August 8. Any concerns will be addressed immediately and discussed with the ID team as indicated. The PI committee will review after 90 days and may adjust the frequency of monitoring, as it deems appropriate. Date of Compliance August 8, 2014		

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F 311	<p>Continued From page 14</p> <p>again, she dipped her fork into her biscuits and gravy, but was unable to lift the loaded fork to her mouth. The resident released the fork.</p> <p>*8:18 AM, OT #16 approached the table, and began attending to Resident #8's tablemate. OT #16 did not look in the direction of Resident #8, cue or assist her, or summon another staff person to help the resident. Resident #8 continued to sit at the table, and was not eating or attempting to eat her meal.</p> <p>*8:21 AM - 8:22 AM, CNA #15 rapidly approached Resident #8's table. CNA #15 asked OT #16 if the OT was working with Resident #8. The OT responded, "No." CNA #15 then stated to the resident, "[Resident #8], want some of your breakfast?" The resident picked up her glass of juice, but did not initiate drinking.</p> <p>*8:24 AM, Resident #8 was sitting at the table with her glass of juice still in her hand. She had been looking at it, but not drinking from it. CNA #15 left the table, with no further cues or assistance for Resident #8. The resident began looking around the room at the other residents and staff, then set her glass of juice back on the table and closed her eyes.</p> <p>*8:29 AM - 8:31 AM, another resident stopped to speak to Resident #8. After that resident left, Resident #8 picked up her glass of juice and took a few sips. She then picked up her milk and took a few sips.</p> <p>*8:36 AM, Resident #8 set her glass of milk on the table and picked up her fork. The resident removed the fork from the biscuits and gravy, placing it instead in her bowl of hard-boiled egg to get a bite. The resident succeeded only in pushing bits of the egg around the bowl, but was not able to get any onto her fork to eat it.</p> <p>*8:37 AM, the resident sat down her fork, no longer attempting to load food onto it.</p>	F 311		

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F 311	<p>Continued From page 15</p> <p>*8:40 AM, OT #16 told CNA #15 that Resident #8 needed more help with breakfast.</p> <p>*8:42 AM, CNA #15 returned to Resident #8's table. CNA #15 pulled the bowl of cream of wheat closer to the resident. CNA #15 asked the resident if the cereal needed sugar. The resident stated, "I don't know." CNA #15 put a packet of sweetener in the bowl, stirred it, and handed the resident a spoon. The resident took a single bite of her cereal. CNA #15 stated to OT # 16, "She's working on it," and left the table.</p> <p>*8:45 AM, CNA # 15 returned to the table, placed a bite of food into the resident's mouth, then left. The resident did not take another bite after the CNA left.</p> <p>*8:47 AM, CNA #15 returned to the table. CNA # 15 stated to the resident, "Don't forget your milk. And you've got coffee too." CNA #15 then moved closer to the OT and began whispering. Neither looked at Resident #8, who at this time had bits of hard boiled egg clinging to her lower lip on her affected side. The resident's eyes were closed. CNA #15 left the table.</p> <p>*8:50 AM, CNA #15 scooted back to Resident #8's table and stated, "You should drink some of your fluids." The resident picked up her glass of milk, but did not initiate taking a drink for over a minute. CNA #17 approached the table and stated to CNA #15, "Are you helping her?" CNA #15 stated, "She won't eat."</p> <p>8:52 AM, CNA #17 stated, "I'll do it," then pulled another stool to the table and began to assist Resident #8 with her breakfast.</p> <p>On 7/9/14, between 5:17 PM and 5:46 PM, Resident #8 was observed in the dining room for the dinner meal [Refer to F 362 as it pertains to meals being served timely]:</p> <p>*5:17 PM, Resident #8 was sitting at the table</p>	F 311		
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F 311	<p>Continued From page 16</p> <p>alone. No food or fluids present.</p> <p>*5:46 PM, Resident #8 was served her dinner meal, which consisted of mechanical soft Swedish meatballs over noodles, a breadstick, Brussels sprouts, and milk. The meal was placed in front of the resident and she was left unattended. The resident did not begin eating her meal.</p> <p>*5:50 PM, the resident picked up her fork and stabbed it into the meatball/noodle combination. Once loaded, the resident was unable to lift the fork from the plate. She released her grip on the fork and closed her eyes.</p> <p>*5:52 PM, RN #1 sat down next to Resident #8, cued the resident to eat, then left the table. The RN was with the resident less than 30 seconds.</p> <p>*5:54 PM, CNA #18 walked up to Resident #8's table, handed the resident her breadstick, told her to eat it, and left the table. CNA # 18 was at the table less than 15 seconds. After the CNA left the table, the resident took one bite of her breadstick.</p> <p>*5:55 PM, Resident #8 picked up her milk, which was in a two-handled cup with a spouted lid. The resident tipped her head back with the spout in her mouth and engaged in a sucking motion with her cheeks, but the liquid in the cup did not move towards the spout [NOTE: The resident's dietary order called for nectar thick liquids]. The resident then sat the cup down, reached into her mouth, and began to pick out bits of breadstick and wiped them on the edge of her plate. The resident then grasped her fork, which was still in her Swedish meatballs, but was unable to lift the fork to take a bite of her food. The resident looked around the room briefly, then put her head down and closed her eyes.</p> <p>For the duration of this observation, the resident had approximately 45 seconds of cues and</p>	F 311		

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F 311	<p>Continued From page 17 assistance from staff.</p> <p>On 7/10/14 at 3:00 PM, the DNS and Nurse Consultant were asked about assistance at meals for Resident #8. The DNS stated the resident had a recent decline in her function, and the facility had completed a change of condition MDS for her, as well as involved therapy for a concern with the resident's ability to swallow. The DNS stated as a result of that consultation, the resident's diet was downgraded to mechanical soft texture with nectar thick liquids. Regarding the amount of assistance the resident needed at meals, the DNS stated the resident would require the same amount of assistance with each meal, but worked with the restorative aide at the noon meal in an effort to maintain what abilities she had. The DNS was asked how that assistance was provided for the meals when the resident was not working with the restorative program. The DNS stated, "Well, any of the aides can help her. It's just that we want restorative working with her for at least one meal." The DNS was unable to explain why there had not been more assistance provided for the resident for the meals observed by the surveyor. [NOTE: Please see F 353 as it pertains to facility staffing.]</p> <p>b. Resident #8's care plan for a focus area of, "Cont[inent of bowel and bladder]. Requires staff assist with toileting..." documented an intervention of, "VOIDING ROUTINE: Upon rising, before and after meals, at [bedtime] and [as needed]..." Date initiated was documented as 10/1/13, revised on 12/17/13.</p> <p>On 7/8/14, between 12:15 PM and 12:51 PM, the Resident #8 was observed at the lunch meal: *12:15 PM, Resident #8 was sitting in her</p>	F 311			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/11/2014
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - NAMPA		STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
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F 311	<p>Continued From page 18</p> <p>wheelchair at the dining room table. CNA # 18 presented the resident with her lunch. The resident requested to be taken to the bathroom before she ate her meal. CNA #18 took Resident #8 to her room in her wheelchair and stated, "I told [CNA #19]. He's going to come and help you to the bathroom." CNA #18 left the room without activating the call light. The resident remained unattended in her room for the next 15 minutes. *12:30 PM, CNA #19 passed Resident #8's room, pulling a metal cart with resident room trays. From the hallway, CNA #19 stated, "I'll be there in a minute," as he passed Resident #8's room. *12:35 PM, CNA #19 returned to Resident #8's room to take her to the bathroom. *12:40 PM, CNA #19 exited the room without the resident. *12:50 PM, CNA # 17 came to look for Resident #8, since she had not yet been to lunch. CNA #17 brought Resident #8 back out of her room and to the dining room.</p> <p>Twenty minutes elapsed between the time Resident #8 asked to use the toilet and the time she was assisted to do so. Thirty-five minutes elapsed between the time the resident left her meal and the time she returned to the meal.</p> <p>On 7/8/14 at 12:51 PM, CNA #19 was asked about assisting Resident #8 to the bathroom during the lunch meal. CNA # 19 stated s/he helped the resident to the bathroom because s/he was assigned, "to the hall." CNA #19 stated s/he had to pass the hall trays before helping the resident to the bathroom. CNA #19 was uncertain when the resident had last been assisted to toilet, because s/he was not assigned to the resident that day.</p>	F 311		

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F 311	Continued From page 19 On 7/8/14 at 1:00 PM, CNA #17 was asked when Resident #8 was last toileted before the lunch meal was served. CNA #17 stated the resident had last used the toilet after the morning exercise class, but had declined when offered again at 11:30 AM. On 7/8/14 at 1:05 PM, LN #2 was asked about the process for toileting residents during meals. LN #2 stated CNA #19's assignment required her/him to finish passing the hall trays before helping residents to the bathroom. LN #2 was informed of the timeframe between Resident #8's request to use the toilet and being assisted to use the toilet. LN #2 stated it seemed too long. When asked if there was anyone else who could have assisted the resident, given CNA #19's assignment to pass the hall trays, LN #2 stated, "I see your point. We could work on that." On 7/10/14 at 4:45 PM, the Administrator, DNS, and Nurse Consultant were informed of the surveyor's findings. The facility offered no further information.	F 311		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by:	F 318	F 318 Resident Specific Nursing management observed resident #4's splints and hand care to be provided as ordered. Other Residents Nursing management reviewed other residents with splints and adaptive devices and adjustments were made to plan of care to provide consistent implementation. Facility Systems	8/8/14

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F 318	<p>Continued From page 20</p> <p>Based on observation, staff interviews, and record review, it was determined the facility failed to ensure hand splints and wash cloths in the palm of the hands were in place as ordered and/or care planned. This was true for 1 of 11 sample residents (#4). Failure to apply splints during the day and wash cloths when the splints were not in use created the potential for the resident's hand/finger contractions to worsen. Findings included:</p> <p>Resident #4 was admitted to the facility in 2007 and readmitted to the facility in 2012 with multiple diagnoses which included Alzheimer's type dementia. In June 2013, Palliative Care was ordered for end-stage dementia.</p> <p>The resident's most recent quarterly MDS assessment, dated 4/12/14, coding included: * severe cognitive impairment; * total assistance for all ADLs; * limited range of motion (ROM) in both upper extremities (UE); and, * restorative nursing program for passive ROM and splinting in the last 6 days .</p> <p>The resident's care plan included the following focus areas and interventions: * ...has actual and is at risk for contracture/impaired functional range of motion...related to contracture to multiple sites..." - "Restorative splinting program...6 [times] a week... Splinting Bi lat [bilateral, or both] UE and Bi lat hands...Apply in Am [morning], wear 6-8 hours. RNA [Restorative Nursing Assistant] to remove..." * "...ADL Self Care Performance Deficit..." - "...Wash cloths in hands when not wearing splints..."</p>	F 318	<p>DNS/SDC has re-educated nursing staff regarding implementation and monitoring of resident splints and adaptive devices, to include but not limited to splint application and use of hand rolls.</p> <p>Monitor The DNS, and/or designee will audit implementation of splints and adaptive devices on two residents per week for 4 weeks, then one resident weekly for 8 weeks. Audits will be documented on the PI monitor beginning the week of August 8. Any concerns will be addressed immediately and discussed with the ID team as indicated. The PI committee will review after 90 days and may adjust the frequency of monitoring, as it deems appropriate.</p> <p>Date of Compliance August 8, 2014</p>		

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F 318	Continued From page 21 The most recent recapitulation (recap) of Physician's Orders in the resident's clinical record was for June 2014. It included the order, "4/9/2012 [-] Hand splints on Q AM off HS...[Hand splints on every morning and off at bedtime...]" On 7/8/14 at 8:15 a.m., the resident was observed in her wheelchair at a table in the Rose Garden dining room. CNA #6 sat next to the resident and fed her. The resident's hands were visible. A splint was not on either of the resident's hands and nothing was in the palm of her hands. The resident's fingers and thumbs were curled inward toward the palm of her hands. On 7/8/14 at 3:00 p.m., the resident was observed turned slightly to the left in bed. The resident's hands were visible. A splint was not on either hand and nothing was in either palm. On 7/10/14 at 9:10 a.m., CNA #4 was observed as she left the resident's room. The resident was asleep on her right side with her hands under the covers. On 7/10/14 at about 10:13 a.m., the resident was in the same position with her hands still covered. About 2 minutes later, the DNS accompanied the surveyor to the resident's room. The DNS uncovered the resident's hands briefly. A splint was not on either hand and nothing was in the either palm. The DNS acknowledged that the splints were not in place and that a wash cloth was not in either palm. The DNS stated, "The RNA applies the splints." On 7/10/14 at 11:30 a.m., splints were observed on both of the resident's hands while CNA #4 and	F 318			

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F 318	Continued From page 22 Rehab Tech #5 transferred the resident from her bed to wheelchair using a Hoyer (Brand of mechanical lift). When asked about the splints, the Rehab Tech stated, "I put them on about 10 minutes ago. The CNAs are going to start putting them on her." When informed that the splints were not on the resident on 7/8/14, the Rehab Tech stated, "I wasn't here on Tuesday. They may well have not been put on her." CNA #4 added, "I don't think they were put on on Tuesday."	F 318			
F 323 SS=E	The facility did not provide any other information which resolved the issue. 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, interview, and record review, it was determined the facility failed to ensure the resident environment was free from hazardous chemicals, and that devices in use with residents were assessed for safety. This was true for 2 of 13 sampled residents (#s 1 and 12), and any resident with access to the 200 hall shower room or the door to resident room #s 6 or 16. The deficient practice had the potential to cause more than minimal harm if a resident experienced skin or eye irritation when exposed	F 323	F 323 Resident Specific Resident #1 & 12 have their bed safety assessments adjusted to include the safety and risk assessment for rails/mobility bars. The Sani cloth wipes have been removed from personal protective equipment caddies and shower room cabinets preventing access of wipes to residents. Observation by the ID team reveals potentially hazardous chemical are consistently secured. Other Residents The ID team reassessed residents with side rails/mobility bars to included documentation for safety. Observation by the ID team reveals potentially hazardous chemical are consistently secured. Facility Systems	8/8/14	

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F 323	<p>Continued From page 23</p> <p>to chemicals, or became entrapped in their side rails. Findings included:</p> <p>1. On 7/7/14 at 9:25 AM, during the initial tour of the facility, resident room #s 6 and 16 were observed with over-the-door caddies hanging on the doors, and stocked with supplies such as disposable gloves, gowns, masks, goggles and booties. The caddies also included white plastic containers with orange lids, filled with disposable wipes. The disposable wipes were in the lower right hand corner of the caddies, approximately 3 1/2 feet from the floor. The wipes were readily accessible to both ambulatory residents, and those in wheelchairs. These same wipes were noted, unsecured, in the unlocked 200 hall shower room. The containers were labeled, "Sani-cloth bleach. Bactericidal, fungicidal, tuberculocidal, and virucidal. Caution - keep out of reach of children."</p> <p>The caddies on the doors to resident room #s 6 and 16 were observed to remain in place throughout the survey, specifically: *7/7/14 at 9:30 AM, 12:45 PM, 1:15 PM, and 3:30 PM; *7/8/14 at 8:00 AM, 11:15 AM, 11:45 AM, and 3:45 PM; *7/9/14 at 10:00 AM, 1:15 PM, 1:45 PM, and 6:00 PM; and *7/10/14 at 8:00 AM, 11:30 AM, 12:00 noon, and 5:00 PM.</p> <p>On 7/10/14 at 8:00 AM, the facility provided the Material Safety Data Sheet (MSDS) for the wipes. The MSDS documented: **"Caution: Causes moderate eye irritation. Avoid contact with eyes or clothing. Wear protective eyewear when dispensing and using this product.</p>	F 323	<p>DNS/SDC has re-educated nursing staff regarding assessment documentation to include side rails/mobility bar safety.</p> <p>SDC has re-educated center staff on locking storage for potentially hazardous chemicals to include Sani wipes. Nursing staff educated to validate chemicals stored appropriately during rounds.</p> <p>Monitor The SDC and/or designee will audit for properly secured chemicals, to include caddies and shower rooms on two halls per week for 4 weeks, then one hall weekly for 8 weeks.</p> <p>The DNS, and/or designee will audit bed safety evaluations for residents with new orders or quarterly re-assessments completed each week for 4 weeks, then one resident weekly for 8 weeks.</p> <p>Audits will be documented on the PI monitor beginning the week of August 8. Any concerns will be addressed immediately and discussed with the ID team as indicated. The PI committee will review after 90 days and may adjust the frequency of monitoring, as it deems appropriate.</p> <p>Date of Compliance August 8, 2014</p>	

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F 323	<p>Continued From page 24</p> <p>Wash thoroughly with soap and water after handling and before eating, drinking, chewing gum, using tobacco, or using the toilet..."</p> <p>***Eye contact. In case of contact, immediately flush eyes with plenty of water...call a poison control center or doctor for treatment advice. Have the product container or label with you when calling."</p> <p>***Skin contact. In case of contact, immediately flush skin with plenty of water. Remove contaminated clothing and shoes. Immediately take off all contaminated clothing."</p> <p>***Handling. Wear protective eyewear while using."</p> <p>***Storage. Keep out of reach of children."</p> <p>***Further information. Not for use on skin. Not a baby wipe. For use on hard surfaces only."</p> <p>On 7/10/14 at 4:45 PM, the Administrator, DNS, and Nurse Consultant were informed of the surveyor's concern with the storage of the wipes, accessible to residents. The Administrator stated, "We've always done that. In fact, I think all of our buildings store those in just that way." However, the facility offered no further information.</p> <p>2. Resident #12 was admitted to the facility on 11/30/13 with multiple diagnoses which included rheumatoid arthritis and CHF.</p> <p>Resident #12's most recent quarterly MDS assessment, dated 5/23/14, coded: *BIMS of 15, indicating the resident was cognitively intact; and *Impendent with bed mobility and transfers.</p> <p>On 4/14/14, a "Bed Safety Evaluation" form for Resident #12 documented the resident used 1/4 side rails on both sides of the bed as an enabler.</p>	F 323		

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F 323	<p>Continued From page 25</p> <p>The form did not document the devices had been assessed as safe for this resident.</p> <p>On 7/7/14 at 9:25 AM, during the initial tour of the facility, and on 7/10/14 at 9:30 AM during a resident interview, Resident #12 was observed to have 1/4 side rails up on each side of her bed. The resident stated, "I grab those sometimes when I need to move."</p> <p>On 7/10/14 at 2:35 PM, the DNS and Nurse Consultant were asked about a safety assessment for the use of side rails for this resident. The DNS stated, "I think we assess for that (safety), but we just don't take credit for it (in the documentation). We will have to educate."</p> <p>On 7/10/14 at 4:30 PM, the Administrator, DNS, and Nurse Consultant were informed of the surveyor's findings. The facility offered no further information.</p> <p>3. Resident #1 was admitted to the facility on 2/9/12 with multiple diagnoses which included restless leg syndrome and muscle weakness.</p> <p>Resident #1's most recent quarterly MDS assessment, dated 5/9/14, documented: * Intact cognition with a BIMS of 15; * Extensive assistance needed with 1 person for bed mobility and transfers; and, * No range of motion impairments.</p> <p>The Care Plan for Resident #1 documented: * Focus - "[Resident's name] had an ADL Self Care Performance Deficit in bathing/dressing/hygiene r/t [related to] chronic pain, osteoarthritis, DM [Diabetes Mellitus], decreased mobility, CKD [chronic kidney</p>	F 323			

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F 323	Continued From page 26 disease], RLS [restless leg syndrome], Kidney CA [cancer], depression/anxiety;" * Interventions - "BED MOBILITY: requires extensive staff participation to reposition and turn in bed." On 7/9/14 at 2:00 p.m., the DON was asked to provide documentation Resident #1 had been assessed as safe with the use of side rails. She provided a Bed Safety Evaluation, dated 6/25/14, which documented the resident used 1/4 side rails as an enabler for turning self in bed. Note: The Bed Safety Evaluation and the clinical record did not document the resident was assessed as safe with the use of side rails. Resident #1 was observed by the surveyor to have bilateral upper side rails in the upright position on 7/9/14 at 3:10 p.m., 4:10 p.m., and on 7/10/14 at 8:20 a.m. On 7/10/14 at 4:30 p.m., the Administrator and DON were informed of the side rails issue. No further information or documentation was provided.	F 323			
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of	F 353	F353 Resident Specific ID team rounds show resident # 4 and 8 have their needs responded to by staff in a timely manner. Resident #21 has discharged from the center. Other Resident ID team completed resident interviews to understand care concerns and timing of	8/8/14	

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F 353	<p>Continued From page 27</p> <p>personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident group interview, observation, resident, family, and staff interviews, and record review it was determined the facility failed to ensure there was adequate nursing staff to respond to residents' needs. This was true for 8 of 8 residents who attended a group interview, 2 of 13 sample residents (#s 4 and 8), and had the potential to affect all other residents who wanted or needed staff assistance. Long call light response times and delays in ADL assistance created the potential for the residents to experience psychosocial and physical harm. Findings included:</p> <p>1. A group interview with 8 residents and 2 surveyors was conducted on 7/8/14 at 2:00 p.m. When asked if there was enough staff to care for everyone, 8 of 8 residents said, "No!" The residents responded as follows: * Six of 8 residents said they had waited 1 hour or more for their call light to be answered; * Two of 8 residents said they had waited up to 2 hours for their call light to be answered;</p>	F 353	<p>meal service. Adjustments were made as indicated.</p> <p>Facility Systems SDC, DNS, and/or ED has re-educated staff regarding meeting of residents needs to include but not limited,</p> <ul style="list-style-type: none"> • Call light answering responsibility of the whole team when staff refer resident to another staff member ensure call light is on. • CNA to validate resident satisfaction when delivering room trays, resolve concern as able. • Stop and watch is completed for resident and or change of condition. • Cart delivery order is adjusted to meet resident needs who dine in their rooms and posted as indicated. <p>Monitor The ED and/or designee will monitor for timely response to residents needs to include:</p> <ul style="list-style-type: none"> • Call light monitor for three alternating meals per week for 4 weeks, then weekly for 8 weeks. • Meal observation of the dining room and hall cart delivery for resident assistance, timeliness of tray delivery, and tray temperatures for three meals per week for 4 weeks, then two meals per week for 8 weeks. • Interview regarding quality of meal for 5 residents per week for 4 weeks, then 2 residents per week for 8 weeks. 	

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F 353	<p>Continued From page 28</p> <p>* One resident said, "It happens every time;"</p> <p>" Another resident said, "My [call] light was on for an hour last night;"</p> <p>* Another resident said, "Depending on what time of day it is, it can be 15 minutes to 2 hours;"</p> <p>* Another resident said, "It revolves around meal times."</p> <p>* Seven of 8 residents said they had waited 30 minutes or more for help before, during, or after meals because "Hoyer people [residents who required 2 staff for mechanical lift transfers]" and residents who needed help to eat had to be helped first;</p> <p>* Eight of 8 residents said sometimes meal carts arrived late and that some of the meals were not served immediately after the carts arrived because staff were "tied up" getting those resident's up who required Hoyer transfers and/or staff had to feed/assist those residents who needed help to eat;</p> <p>* One resident said, "A whole bunch of people have to be fed and there really is not enough help;"</p> <p>* Seven of 8 residents said dinner hall meal trays were sometimes served late because the meal carts arrived late and only 1 staff was available to pass out room trays while the other staff feed/assisted residents to eat and that it could be 7:00 p.m. before residents on halls 400 and 500 got to eat;</p> <p>Note: Refer to F362 regarding sufficient support personnel for dietary services.</p> <p>* Eight of 8 residents said the problems could occur at any time or any mealtime.</p> <p>* Eight of 8 residents said the aforementioned call light response and meal problems had been brought up during Resident Counsel Meetings with staff present and, "Usually the budget is the reason they give."</p>	F 353	<ul style="list-style-type: none"> The ED will participate in meal service meeting weekly for 8 weeks. <p>Audits will be documented on the PI monitor beginning the week of August 8. Any concerns will be addressed immediately and discussed with the ID team as indicated. The PI committee will review after 90 days and may adjust the frequency of monitoring, as it deems appropriate.</p> <p>Date of Compliance August 8, 2014</p>		

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F 353	<p>Continued From page 29</p> <p>2. Review of Resident Council meeting minutes dated 4/28/14, 5/28/14, and 6/23/14 revealed nothing was documented about complaints about call lights or late meals.</p> <p>On 7/10/14 at 11:40 a.m., the Licensed Social Worker (LSW) was asked about the Resident Council meeting minutes. The LSW said she was "fairly new" and had worked part-time since December 2013. The LSW said the residents had not complained to her about call light and food was brought up for the first time during the June Resident Council meeting. The LSW said the Resident Council meeting minutes reflected only the part of the meeting that she attended and the Dietary Manager (DM) and the Activities Director (AD) met separately with the Resident Council. The LSW said she would ask the DM and AD if they documented their meetings with the Resident Council.</p> <p>Later that day, the LSW provided Menu Meeting Notes and Activity Notes for the Resident Council meetings in April, May, and June 2014. The Menu Meeting Notes included the question, "Have your meals been arriving timely?" The answer was "for the most part" in April and "yes" in May and June. There was no other documentation about the timeliness of the meals.</p> <p>3. On 7/9/14 at 5:40 p.m., the DNS was asked to provide a list of residents who required 2 person assistance for mobility, transfers, and toileting.</p> <p>The DNS provided the requested on 7/10/14 at 3:35 p.m. The list included 61 resident names with 14 names highlighted in yellow to signify they required 2 person assistance, 11 of which also</p>	F 353			

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F 353	<p>Continued From page 30</p> <p>had an "H" next to them to signify they required Hoyer transfers. Of the 14 residents who required 2 person assistance, 4 lived on the 200 hall, 1 lived on the 300 hall, and 3 each lived on the 100, 400, and 500 halls.</p> <p>Refer to F311, for details about the lack of eating and toileting assistance for Resident #8 who was dependent for eating and toileting assistance.</p> <p>4. On 7/9/14 at 3:55 p.m., CNA #13 was interviewed. When asked how many of her residents required 2 person Hoyer transfers, the CNA said, "Four on hall 200. I can get a CNA from [hall] 4/5 [400/500] or 1/3 [100/300] or a nurse to help me." When asked about meals, the CNA stated, "I pass meal carts on [hall] 200 and I'll keep an eye on my residents and I can also go to the Rose Garden DR if I need to."</p> <p>5. On 7/9/14 from 5:00 p.m. to 6:00 p.m., in the Rose Garden dining room, 3 CNA students, the CNA Instructor, and up to 5 facility staff were observed as they assisted as many as 25 residents during the dinner meal service.</p> <p>When asked, the CNA Instructor said the CNA Students were usually in the facility every Wednesday and Thursday from 2 to 10 p.m. during school.</p> <p>6. On 7/10/14 at 11:50 a.m., Resident #4's family member was interviewed by telephone. When asked if there was sufficient staff to care for the resident, the family member said that after dinner, call lights would be on and "nobody's around even at the nurses' medication cart." The family member said other residents have asked her to help them." The family member said, "You often</p>	F 353		

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F 353	Continued From page 31 hear 'we're short staffed' or 'someone called in sick.'" The family member said, "They don't have the staff to go down and change [the resident] during a meal because they are needed in the dining room." The family member said that during the dinner meal, "When the [student CNAs] are not there, I don't think there's enough staff to take care of everyone. Sometimes there's only 2 CNAs in the Rose Garden dining room. On Saturday nights, I feel bad for some residents because they have to wait." 7. On 7/10/14 at about 2:50 p.m., Resident #21 commented to LN #14 and 2 surveyors that 9 people (staff and CNA Students/Instructor) had helped in the Rose Garden dining room during the evening meal on 7/9/14. The resident laughed and said it was funny because "usually there's only 2 people to help." On 7/10/14 at 4:30 p.m., the Administrator, DNS, and Nurse Consultant were informed of the staffing issue. The facility did not provide any other information which resolved the issue.	F 353			
F 362 SS=E	483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL The facility must employ sufficient support personnel competent to carry out the functions of the dietary service. This REQUIREMENT is not met as evidenced by: Based on staff interview, a resident group interview, and observation, it was determined the facility failed to ensure there was sufficient dietary	F 362	F362 Resident Specific No specific residents were identified. Other Residents ID team completed resident interviews to understand care concerns and timing of meal service. Adjustments were made as indicated. Facility Systems Dietary Manager/ED educated dietary staff on timeliness of tray delivery and completion of tray delivery log. A delivery	8/8/14	

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F 362	<p>Continued From page 32</p> <p>support staff to prepare and deliver meals at scheduled times. This affected 6 of 8 residents in the group interview, 13 of 13 sample residents (#s 1-13), and had the potential to affect any residents who ate meals prepared in the facility's kitchen. Failure to serve meals on time created the potential for the food to be cold and not palatable. Findings included:</p> <p>1. On 7/7/14 at 9:40 a.m., during the initial tour of the kitchen with the Dietary Manager (DM) in attendance, the DM said they were "short staffed."</p> <p>On 7/9/14 at 2:50 p.m., the DM stated, "It depends on staff related to when hall meal carts arrive versus when they are actually delivered."</p> <p>2. On 7/8/14 at 2:00 p.m., 2 surveyors conducted an interview with a group of 8 residents. When asked if meals were generally on time or late, all 8 residents said the meals were late sometimes and sometimes the meals came from the kitchen late. One resident said "frequently" residents on halls 400 and 500 did not get their evening meal until 7:00 p.m. Another resident said "frequently" only 1 staff was available to pass out meal trays on halls 400 and 500 because other staff had to feed residents. Another resident stated, "A whole bunch of people have to be fed and there's really not enough help." Refer to F353, Nursing Services, for details about insufficient nursing staff.</p> <p>3. The meal service times observed posted in the facility and provided to the survey team on 7/7/14 included:</p> <p>DINNER: TO ARRIVE AT UNIT BETWEEN:</p>	F 362	<p>schedule is posted and a time log is initiated to determine compliance of delivery times. Dining room and hall tray cart delivery times were reordered to meet resident needs.</p> <p>Monitoring ED and/or dietary manager will review delivery schedule logs 5x weekly for 4 weeks then twice weekly for 8 weeks. Adjustments to be made to tray line process and tray delivery as indicated. See F353 for monitoring also. Audits will be documented on the PI monitor beginning the week of August 8. Any concerns will be addressed immediately and discussed with the ID team as indicated. The PI committee will review after 90 days and may adjust the frequency of monitoring, as it deems appropriate.</p> <p>Date of Compliance August 8, 2014</p>	

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F 362	Continued From page 33 * Unit 3 - 5:00 p.m. to 5:10 p.m. * 1 Hall - 5:05 p.m. to 5:15 p.m. * RNA (Restorative Nursing) & 1st Rose Garden - 5:10 p.m. to 5:20 p.m. * 2nd Rose Garden - 5:15 p.m. to 5:35 p.m. * Parkside Cafe - 5:20 p.m. to 5:35 p.m. * 2 Hall - 5:25 p.m. to 5:40 p.m. * 4/5 Hall - 5:30 P.M. to 5:45 p.m. On 7/9/14 from 5:05 p.m. to 6:05 p.m., the following was observed during the dinner meal service: * Unit 3 meal cart arrived at 5:30 p.m., first meal served in room 305 at 5:35 p.m. This was 20 minutes later than the latest scheduled arrival time; * 1st Rose Garden meal cart arrived at 5:45 p.m., first meal served at 5:46 p.m.. This was 25 minutes later than the latest scheduled arrival time; * 2nd Rose Garden meal cart arrived at 5:55 p.m. This was 20 minutes later than the latest scheduled arrival time; * By 6:05 p.m., the 4/5 Hall meal cart still had not come out of the kitchen. This was at least 20 minutes later than the latest scheduled arrival time. On 7/10/14 at 4:30 p.m., the Administrator, DNS, and Nurse Consultant were informed about staffing concerns. The facility did not provide any other information regarding the issue.	F 362			
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them.	F 369	F369 Resident Specific Resident #8 was reassessed by occupational therapy for adaptive equipment. The curved spoon is no longer needed and the resident plan of care updated.	8/8/14	

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F 369	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure a resident had adaptive equipment, per her plan of care, available at meal time. This was true for 1 of 9 sampled residents (#8) observed during meals. The deficient practice had the potential to cause more than minimal harm if a resident experienced weight loss from being unable to feed herself. Findings included: Resident #8 was admitted to the facility on 5/23/10 with multiple diagnoses which included CVA with right-sided hemiparesis, aphasia, and HTN. Resident #8's most recent significant change of condition MDS assessment, dated 5/15/14, coded: *BIMS of 14, indicating the resident was cognitively intact; and, *Supervision after set-up for eating. Resident #8's care plan for the focus area of "...at risk for malnutrition..." documented an intervention of, "...[left] hand curved spoon with every meal." Date initiated was documented as 4/13/13, revised on 6/3/14. Resident #8 was observed at meals, without her curved spoon, as follows: *7/8/14, 8:10 AM - 8:52 AM, breakfast. *7/8/15 12:51 PM, lunch. *7/9/14, 5:46 PM - 5:55 PM, dinner. On 7/10/14 at 3:00 PM, the DNS and the Nurse Consultant were asked about the curved spoon	F 369	Other Residents Other residents were reviewed by therapy/nursing for use of current adaptive utensils or potential need of adaptive utensils. Orders were received as indicated and care plans were adjusted. Facility Systems DNS/SDC has re-educated nursing and dietary staff regarding implementation of adaptive utensils as identified on tray card for residents with care plan directives. Nursing staff educated on monitoring for provision of adaptive utensil during meal service and communication to therapy staff with newly identified concerns. Monitor The DNS, and/or designee will audit implementation of adaptive utensils for two residents per week for 4 weeks, then one resident weekly for 8 weeks. Audits will be documented on the PI monitor beginning the week of August 8. Any concerns will be addressed immediately and discussed with the ID team as indicated. The PI committee will review after 90 days and may adjust the frequency of monitoring, as it deems appropriate. Date of Compliance August 8, 2014		

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F 369	Continued From page 35 for Resident #8. The DNS stated the curved spoon should have been placed on the resident's tray when her meal was prepared, so she had it when her food arrived. The DNS stated she was uncertain why that had not happened during the surveyor's observations, but would investigate. On 7/10/14 at 4:30 PM, the Administrator, DNS, and Nurse Consultant were informed of the surveyor's findings. The facility offered no further information.	F 369		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure food was prepared and maintained under sanitary conditions. This had the potential to affect 13 of 13 sampled residents (#s 1-13) and any other resident who dined in the facility. This practice created the potential for contamination of food and exposed residents to potential sources of disease causing pathogens. Findings included: On 7/7/14 at 9:30 a.m., the Supervisor of	F 371	<p>F371 Resident Specific No specific residents were identified.</p> <p>Other Residents The stove back splash was cleaned immediately as noted in the CMS-2567.</p> <p>Facility Systems The dietary manager/ ED has educated the kitchen staff to the daily cleaning schedule. The daily cleaning schedule is updated to include the stove back splash cleansing. The documented cleaning schedule is reviewed by the dietary manager for quality outcomes. Weekly kitchen sanitation rounds are completed by the dietary manager.</p> <p>Monitor The Executive Director (ED) and/or designee completes weekly rounds for 8 weeks to validate kitchen sanitation, to include but not limited to stove back splash. Audits will be documented on the PI monitor beginning the week of August 8. Any concerns will be addressed immediately and discussed with the ID team</p>	8/8/14

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F 371	Continued From page 36 Nutritional Services (SNS) accompanied the surveyor during the initial tour of the facility's kitchen. The following was observed by the surveyor: The stove backsplash had a layer of dark brown, dark orange grime on the lower portion of the backsplash. The SNS said they had been short staffed and she was assisting with cleaning in the kitchen the day prior but had not been able to reach the lower portion of the backsplash because pots were in the stove preventing her from reaching the area. When asked if the grime was from cooking breakfast that morning, the SNS said, "No." On 7/9/14 at 11:15 a.m., the stove backsplash was observed to be clean with no evidence of the dark brown layer of grime. On 7/10/14 at 4:30 p.m., the Administrator and DON were informed of the kitchen issues. No further information or documentation was provided.	F 371	as indicated. The PI committee will review after 90 days and may adjust the frequency of monitoring, as it deems appropriate. Date of Compliance August 8, 2014		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431	F 431 Resident Specific Resident #19 has discharged from the center. Expired medications were destroyed by the licensed nurse. Other Residents Clinical nursing management review shows no other IV piggyback medications are currently being used from the emergency kit. Observation shows all IV's with	8/8/14	

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F 431	<p>Continued From page 37</p> <p>professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview and Policy and Procedure review, it was determined the facility failed to ensure expired medications, were not available for administration to residents, and an intravenous medication solution bag was properly labeled. This was true for 2 of 5 medication carts and 1 of 5 (#19) random residents. This created the potential for sub-optimal efficacy by any resident who could have received the expired medication, and the potential for inaccurate medication administration. Findings included:</p> <p>The Policy and Procedure Storage and Expiration</p>	F 431	<p>pharmacy labels, initials and dates of times hung.</p> <p>Clinical nursing management reviewed the medication carts and medication rooms for expired medication. No additional expired items were identified.</p> <p>Facility Systems SDC has re-educated licensed nurse staff regarding proper management of medications to include but not limited to proper labeling of IV piggybacks from the emergency kit, providing date and initial of nurse who hung, and check expiration dates of Over-the-Counter (OTC) medications in the medication cart. Labels are placed in the IV emergency kit for use when admixing IV solutions.</p> <p>Monitor The SDC and/or designee will audit for IV labeling, dating and initialing for all units weekly for 4 weeks and one unit weekly for 8 weeks. Med carts will be checked for expired meds the last week of each month. Audits will be documented on the PI monitor beginning the week of August 8. Any concerns will be addressed immediately and discussed with the ID team as indicated. The PI committee will review after 90 days and may adjust the frequency of monitoring, as it deems appropriate.</p> <p>Date of Compliance August 8, 2014</p>	

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F 431	<p>Continued From page 38</p> <p>of Medications, Biologicals, Syringes and Needles, dated 1/1/13, documented, "4. Facility should ensure that medications and biologicals:...4.2 Have not been retained longer than recommended by manufacturer or supplier guidelines..."</p> <p>1. On 7/9/14 at 3:15 p.m., during inspection of the 500 hall medication cart with LN #1 in attendance, a bottle of Loperamide was observed as expired in April 2014. The LN was asked to read the expiration date on the bottle and she stated, "4 of 14," and added a nurse had gone through the medication carts the week prior to remove any expired medications.</p> <p>On 7/9/14 at 3:25 p.m., during inspection of the 300 hall medication cart with LN #2 in attendance, a box of Cepacol sore throat lozenges was observed as expired in April 2014. The LN was asked to read the expiration date on the box and she stated, "4/14."</p> <p>On 7/9/14 at 5:26 p.m., the DON was asked about the process for expired medication. She said the nurses go through the carts about weekly and Central Supply writes the expiration date in black marker on the top of the bottle for a visual for the nurses.</p> <p>On 7/10/14 at 4:30 p.m., the Administrator and DON were informed of the expired medication issues. No further information or documentation was provided.</p> <p>2. On 7/7/14 at 10:00 a.m., during the initial tour of the facility with LN #2 in attendance, an empty IV (intravenous) bag of 0.9% Sodium chloride 250 milliliters (ml) and tubing was observed on an IV</p>	F 431			

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F 431	<p>Continued From page 39</p> <p>pump pole in Resident #19's room. The word "Rocephin" was handwritten on the IV bag. "Rocephin" was written in what looked like black permanent marker. The IV bag did not have a label on it. The date, nor the time, the IV Rocephin was mixed and administered was not noted anywhere on the IV bag. The dosage of the Rocephin was not noted anywhere on the IV bag. When asked about the IV bag with Rocephin, LN #2 stated, "Usually there's a date and time. Our policy is to make sure there's a date and time hung and initials [of the staff who administered the medication]." When asked what the dosage of the Rocephin was, the LN said she did not know. The LN said she would find out when the IV Rocephin was hung and what the dosage was.</p> <p>The resident's recapitulation of Physician's Orders for July 2014 included, "Ceftriaxone [brand name Rocephin] 2 gm Intravenous QD X 30 days...[Rocephin 2 grams per IV route every day times 30 days...]." The order was dated 6/17/14.</p> <p>In the afternoon on 7/10/14, the DNS was asked to provide the facility's policies and procedures (P&P) regarding the administration of IV antibiotics.</p> <p>On 7/10/14 at about 3:45 p.m., the DNS and the Nurse Consultant (NC) provided an "IV Therapy" P&P. They indicated they did not have any other P&Ps regarding the administration of IV antibiotics.</p> <p>The IV Therapy P&P included, "COMPONENTS: ...Licensed nurses follow IV policies and procedures of provider pharmacy for...administration of IV solutions and</p>	F 431		

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F 431	<p>Continued From page 40</p> <p>medication...When medications are added to an IV solution, the licensed nurse completes a medication label affixes it to the IV solution bag to inform others...of the contents of the bag..."</p> <p>On 7/10/14 at 4:30 p.m., the Administrator, DNS, and NC were informed of the labeling issue regarding the IV antibiotic.</p> <p>On 7/11/14 at 9:55 a.m., the Administrator was called and asked to provide a copy of a medication label and the provider pharmacy's IV P&Ps.</p> <p>On 7/11/14 at about 11:00 a.m., the NC, with the DNS present, said the facility did not use medication labels and that staff should "never" write directly on an IV bag. The NC provided 3 provider pharmacy P&Ps. The 3 P&Ps were, "Admixing Medications" "Labeling of Infusions" and "Administration of an Intermittent Infusion."</p> <p>The P&Ps documentation included: * Admixing Medications, "...Admixed IV solutions must have a completed "medication added" label attached...Label IV solution container with "medication added" label to include the following: 12.1 Resident's name 12.2 IV solution/volume/diluent 12.3 Medication added 12.4 Medication dose 12.5 Route and rate...12.7 Time medication added 12.8 Date medication added 12.9 Date and time of administration...12.12 Initials of nurse preparing/administering medication..." * Labeling of Infusions, "...All infusions must be appropriately labeled...All labels shall be checked by nursing staff prior to medication administration...All infusions admixed in the nursing facility will be labeled by the licensed</p>	F 431			

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F 431	Continued From page 41 nurse who admixes the solution...Labels should include...[same as in Admixing Medications P&P]..." * Administration of an Intermittent Infusion, "...Equipment: ...Administration set label..." The facility did not provide any other information regarding the issue.	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	F 441 Resident Specific Resident #17's urinal was removed immediately from overbed table with water pitcher replacement and table sanitation. Resident #19's nebulizer machine was removed from floor, sanitized and stored properly. Other Residents ID team observations provide ongoing observation for breaches in infection control. Errors are corrected immediately with re-education and/or performance improvement plans when indicated. Facility Systems DNS/SDC has re-educated licensed nurse staff regarding proper infection control procedures to include but not limited to urinals on bedside tables and nebulizer machines placed on the floor. Nursing supervisor rounds are completed to observe for and correct breaches in infection control practices. Monitor	8/8/14	

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F 441	<p>Continued From page 42 hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility did not ensure resident care equipment was stored in a sanitary manner. This was true for 2 random residents (#s 17 and 18). The deficient practice had the potential to cause more than minimal harm if residents experienced infection from using equipment or supplies which had been stored incorrectly. Findings included:</p> <p>1. On 7/7/14 at 9:35 AM, during the initial tour of the facility, RR # 17 was observed laying in his bed. His overbed table was to his left hand side, and contained both his urinal and his water mug. They were positioned so closely to one another that the base of the mug touched the urinal.</p> <p>2. On 7/7/14 at approximately 10:30 AM, during the initial tour of the facility, RR #18 was observed in her room laying in bed. A pink basin was on the floor underneath the head of her bed, with her nebulizer machine and mask inside.</p> <p>On 7/7/14 at 11:00 AM, RN #1 was asked about placement of the urinal next to the water mug for RR #17. RN #1 stated, "No, that's not OK. I'll fix it." RN #1 was also asked about storage for the</p>	F 441	<p>The SDC and/or designee will audit 2 halls weekly for 4 weeks and then one hall weekly for 8 weeks related to infection control protocol. Audits will be documented on the PI monitor beginning the week of August 8. Any concerns will be addressed immediately and discussed with the ID team as indicated. The PI committee will review after 90 days and may adjust the frequency of monitoring, as it deems appropriate.</p> <p>Date of Compliance August 8, 2014</p>		

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F 441	Continued From page 43 nebulizer machine for RR #18. RN #1 stated when the resident was finished with her treatment, the nurse should collect the machine and store it on the medication cart. When informed of the surveyor's observation of the machine inside the pink basin on the floor, RN #1 stated, "Oh, no. It should not be on the floor. I'll go right now and take care of that." On 7/10/14 at 4:30 PM, the Administrator and DNS were informed of the surveyor's findings. The facility offered no further information.	F 441			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the dosage of an antibiotic and which hip was fractured were accurately documented; all documents were dated; and, that a final diagnosis or cause of death was included in the medical	F 514	F514 Resident Specific Resident #6 and 19 have discharged from the center. As noted in the CMS-2567, Resident # 14 was a discharged resident prior to survey. Other Residents Clinical management team reviewed IV orders to validate accurate transcription of dosing. No adjustments were indicated. Clinical management team reviewed residents with hip fractures, wounds, and/or adaptive equipment to validate correct location is noted. Adjustments were made as indicated. Medical records reviewed residents who have expired at the center and validates each has a death certificate on file for 2014. Facility Systems DNS/SDC has re-educated licensed nursing staff regarding accurate transcription of	8/8/14	

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F 514	<p>Continued From page 44</p> <p>record for a resident who died in April, 2014. This was true for 1 of 13 sample residents (#6), 1 of 5 random residents (#19), and 1 of 2 closed records (#14) reviewed. These failures created the potential for more than minimal harm if Resident #19 received an incorrect dosage of Rocephin (antibiotic) and if staff did not know which of Resident #6's hips was fractured. Findings included:</p> <p>1. On 7/7/14 at about 10:00 a.m., during the initial tour of the facility with LN #2 in attendance, an empty IV (intravenous) bag of 0.9% Sodium chloride 250 milliliters (ml) and tubing was observed on an IV pump pole in Resident #19's room. The word "Rocephin" was handwritten on the IV bag.</p> <p>The resident's recapitulation of Physician's Orders for July 2014 included, "Ceftriaxone [brand name Rocephin] 2 gm Intravenous QD X 30 days...[Rocephin 2 grams per IV route every day times 30 days...]." The order was dated 6/17/14.</p> <p>The resident's June 2014 Medication Record (MR) included the aforementioned ceftriaxone order and documented the IV antibiotic was administered daily from 6/17 through 6/30/14.</p> <p>An undated MR also included an order for ceftriaxone; however, it was for 2 milligrams (mg), not 2 grams. This MR documented the 2 mg dosage of ceftriaxone was administered daily from the 1st through the 8th of the unknown month and year. Note: The difference between 2 mg and 2 gm is 1,998 milligrams.</p>	F 514	<p>physician orders, to include but not limited to, dosing – grams (GM) vs milligrams (mg), location – right and left. If an error is identified education was provided on standard of practice to correct the error.</p> <p>SDC/ ED educated medical records staff on requirements for death certificate with physician signature and cause of death to be available in the closed record.</p> <p>Monitor DNS and/or designee will review physician order transcription for accuracy to include but not limited to IV dosing and site of resident injury for one unit per week for 8 weeks.</p> <p>ED will monitor closed records of each resident death for validation of death certificate, with physician signature and cause of death, for the next 8 weeks.</p> <p>Audits will be documented on the PI monitor beginning the week of August 8. Any concerns will be addressed immediately and discussed with the ID team as indicated. The PI committee will review after 90 days and may adjust the frequency of monitoring, as it deems appropriate.</p> <p>Date of Compliance August 8, 2014</p>	

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F 514	<p>Continued From page 45</p> <p>On 7/11/14 at about 11:00 a.m., the DNS and Nurse Consultant (NC) were asked about the documentation issues regarding the resident's Rocephin dosage and undated MR. After reviewing the undated MR which documented ceftriaxone 2 mg, the DNS and NC acknowledged the inaccuracy and the DNS said the undated MR was for July 2014.</p> <p>2. Resident #6 was admitted to the facility on 6/2/14, had a fall resulting in a right hip fracture on 6/9/2014 and left the facility for surgical intervention and was readmitted on 6/13/2014. Resident #6 had multiple diagnoses including right hip fracture, abscess of anal and rectal region, dysphagia, peripheral vascular disease, and hypertension.</p> <p>A local hospital's Admission History & Physical report dated 6/10/14 documented resident was admitted to the hospital with a right hip fracture after a fall.</p> <p>The resident's 6/13/14 Admission Physician's Orders documented, "Diagnosis: R [right] hip fx [fracture] ORIF [open reduction internal fixation]..."</p> <p>The resident's 6/14/14 Physician Order documented, "Cleanse R hip surgical site..."</p> <p>Resident #6's CAA dated 6/26/14 documented in the following areas: * "Cognitive loss/Dementia...L [left] hip fx [fracture]...; * ADL Functional/Rehabilitation Potential...L hip fx...; * Urinary Incontinence and Indwelling Catheter... L hip fx...;</p>	F 514		

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F 514	<p>Continued From page 46</p> <ul style="list-style-type: none"> * Falls...L hip fx...; * Pressure ulcers...L hip fx...; * Pain...L hip fx..." <p>Resident #6's Care Plan documented the focus as:</p> <ul style="list-style-type: none"> * Impairment to skin integrity from surgical incision at *right hip. * ADL Self Care Performance deficit r/t (related to) *left hip fracture. * Risk for falls r/t *right hip fracture. * Acute pain r/t *left hip fracture. <p>The resident's right hip was fractured but there were no issues with her left hip.</p> <p>Resident #6's nursing progress notes documented:</p> <p>6/13/14 4:14 PM "...following hospitalization for right hip fx...Dressing intact to incision right hip..."</p> <p>6/14/14 3:25 PM "...Pt returned to facility on 6/13/14 after fall with left hip fx..."</p> <p>6/15/14 10:51 PM "...Incision to Rt [right] hip..."</p> <p>On 7/7/14 at 2:20 PM, interview with Resident #6 and she stated, "I fell and fractured my right femur."</p> <p>3. Resident #14 was admitted to the facility on 3/25/14 with multiple diagnoses including acute nonhemorrhagic stroke, hypertension, chronic renal insufficiency, dementia, and aphasia and was discharged/death on 4/7/14.</p> <p>The resident's Physician Order dated 4/7/14 documented "Ok to release patients body to funeral home of choice..."</p> <p>On 7/10/14 at 1:45 PM, HIM #10 was asked for</p>	F 514			

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F 514	<p>Continued From page 47</p> <p>the cause of death or final diagnosis for Resident #14. This information was not able to be located in the resident's chart.</p> <p>On 7/10/14 at 2:25 PM, HIM #10 provided an unofficial death certificate abstract. When asked when she had received the document she stated, "I just got it now from the funeral home after I called." The HIM was further questioned on why it was unofficial and no physician signature. She said she thought it could be electronically signed and would obtain the information from the funeral home.</p> <p>On 7/10/14 at 2:46 PM, HIM #10 provided the death certificate worksheet for Resident #14 that was signed by the physician and listed cause of death.</p> <p>On 7/10/14 at 4:30 PM, the Administrator and the DON were informed of the finding. The facility did not provide any additional documentation that resolved the issue.</p>	F 514			

Bureau of Facility Standards

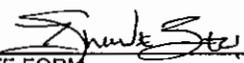
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NAME OF PROVIDER OR SUPPLIER
KINDRED NURSING & REHABILITATION - NAM

STREET ADDRESS, CITY, STATE, ZIP CODE
**404 NORTH HORTON STREET
NAMPA, ID 83651**

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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the annual State licensure survey of your facility. Findings in this report reflect changes made through the IDR process. The surveyors conducting the survey were: Lauren Hoard, RN, BSN, Team Coordinator Nina Sanderson, BSW, LSW Linda Kelly, RN Linda Hukill-Neil, RN	C 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation - Nampa does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
C 111	02.100,02,f Provide for Sufficient/Qualified Staff f. The administrator shall be responsible for providing sufficient and qualified staff to carry out all of the basic services offered by the facility, i.e., food services, housekeeping, maintenance, nursing, laundry, etc. This REQUIREMENT is not met as evidenced by: Refer to F353 and F362 as it related to sufficient staffing.	C 111	C 111 Please refer to POC for F 353 and F362	8/8/14
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Refer to F371 as it relates to sanitary conditions	C 325	C 325 Please refer to POC for F 371	8/8/14

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE **EXECUTIVE DIRECTOR** (X6) DATE **08/05/14**

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - NAM	STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651
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(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 325	Continued From page 1 in the kitchen.	C 325		
C 669	02.150,03 PATIENT/RESIDENT PROTECTION 03. Patient/Resident Protection. There is evidence of infection control, prevention and surveillance in the outcome of care for all patients/residents as demonstrated by: This Rule is not met as evidenced by: Refer to F441 as it relates to infection control.	C 669	C 669 Please refer to POC for F 441	8/8/14
C 780	02.200,03,a,ii Coordinated with Other Care Services ii. Developed in coordination with other patient/resident care services provided to the patient/ resident; This Rule is not met as evidenced by: Refer to F309 as it related to coordination of care with a dialysis provider.	C 780	C 780 Please refer to POC for F 309	8/8/14
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: Refer to F280 as it related to care plans revisions.	C 782	C 782 Please refer to POC for F 280	8/8/14
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 as it relates to preventing accidents	C 790	C 790 Please refer to POC for F 323	8/8/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001550	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/11/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - NAM	STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651
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C 790	Continued From page 2 related to side rails.	C 790		
C 796	02.200,03,b,xii Rehabilitative Nursing Standards xii. Rehabilitative nursing current with acceptable professional practices to assist the patient/resident in promoting or maintaining his physical functioning. This Rule is not met as evidenced by: Refer to F318 as it related to contractures.	C 796	C 796 Please refer to POC for F 318	8/8/14
C 822	02.201,01,c Medication Storage and Dangerous Chemicals c. Reviewing the facility for proper storage of medications and dangerous chemicals at least every thirty (30) days and notifying the administrator of the facility of any nonconformance. This Rule is not met as evidenced by: Refer to F431 as it relates to labeling and expired medications.	C 822	C 822 Please refer to POC for F 431	8/8/14
C 832	02.201,02,f Labeling of Medications/Containers f. All medications shall be labeled with the original prescription legend including the name and address of the pharmacy, patient's/resident's name, physician's name, prescription number, original date and refill date, dosage unit, number of dosage units, and instructions for use and drug name. (Exception: See Unit Dose System.) This Rule is not met as evidenced by:	C 832	C 832 Please refer to POC for F 431	8/8/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001550	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/11/2014
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C 832	Continued From page 3 Refer to F431 as it relates to medication labels.	C 832		
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Refer to F514 as it related to accurate and complete medical records.	C 881	C 881 Please refer to POC for F 514	8/8/14



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
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August 8, 2014

Todd "Shane" Bell, Administrator
Kindred Nursing & Rehabilitation - Nampa
404 North Horton Street
Nampa, ID 83651-6541

Provider #: 135019

FILE COPY

Dear Mr. Bell:

On **July 11, 2014**, a Complaint Investigation survey was conducted at Kindred Nursing & Rehabilitation - Nampa. Lauren Hoard, R.N., Nina Sanderson, L.S.W., Linda Kelly, R.N. and Linda Hukill-Neil, R.N. conducted the complaint investigation.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006298

ALLEGATION #1:

The complainant stated the equipment used by the facility to obtain vital signs for the residents was not being recharged regularly, which on at least one occasion caused a delay in obtaining the vital signs for an unidentified ill resident.

The complainant stated the facility's four mechanical lifts have batteries that are either not charged or worn out, so a machine may only be used for one lift at a time before it has to be recharged. The complainant also stated the structure of the mechanical lifts is bent and the legs don't always close when the lifts are being used.

FINDINGS #1:

The survey team inspected the equipment mentioned in the complaint; conducted staff, resident group, individual resident and resident's family interviews; observed mechanical lift transfers;

reviewed the facility's grievance logs and maintenance logs; reviewed the facility's accident and incident reports and reviewed the facility's policies and procedures. Thirteen records were reviewed for current residents, and two records were reviewed for discharged residents.

All equipment examined by the surveyors was in good working order, batteries were charged and functioning.

Multiple Certified Nurses Aides (CNAs) and Licensed Nurses (LNs) were interviewed. In sum, these interviews revealed the facility typically used a "vital signs kit," which was a portable electronic device capable of measuring temperature, oxygen levels, pulse, and blood pressure. The devices were battery-operated and rechargeable. Two of the staff interviewed stated that on occasion, the battery on the machine they were using would die, so they would get another machine while the one they had been using was recharged. Of the two staff who had experienced dead batteries, both stated they had no trouble locating another machine which could be used, as there was always at least one machine charging while the others were in use. When asked what would happen if none of the machines was operational, the staff interviewed insisted that had never happened. However, if it did happen, the staff all stated they would take vital signs, "the old-fashioned way," meaning with manual equipment which was also available in the facility. LNs interviewed stated they felt vital signs taken manually would be accurate enough, and could be obtained quickly enough, that physicians could be notified timely and treatment decisions could be made accurately and without delay. All staff interviewed felt they had adequate training and equipment to take vital signs manually, if needed.

The same nursing personnel were interviewed regarding the facility's mechanical lifts. The staff interviews revealed, in sum, that the facility had a number of rechargeable battery-operated mechanical lifts. While none of the nursing staff interviewed was certain of the number of lifts the facility had, they all felt there were an adequate number. The personnel interviewed stated the lifts were kept in a designated room in the facility, and at least one lift was plugged in and charging at all times. The staff reported once charged, the lifts would usually last, "most of the shift, if not all of the shift." Two CNAs reported on occasion, the battery on the lifts would begin to die before the end of the shift. The CNAs stated this did not happen suddenly, but the operator would notice the speed of the machine to, "slow down." When this happened, the CNAs would take the machine to the designated room, plug it in, and obtain another machine. One CNA stated that while it had never happened, she had been trained how to handle an emergency if the lift suddenly quit working during a resident transfer, via a manual control on the machine for just such a purpose. None of the staff interviewed had noticed any structural abnormalities with the machines, or experienced a time when the legs of the machine did not close during use when needed. All stated if they felt a machine was in need of repair, they would put it to the side of the room, put a sign on it to warn other staff, and fill out a maintenance slip so the machine could be inspected.

Todd "Shane" Bell, Administrator
August 8, 2014
Page 3 of 3

None of the residents interviewed individually or as a group reported awareness of difficulty with either the vital signs machines or the mechanical lifts. The residents' families interviewed also revealed no awareness of such problems.

The Maintenance Director was interviewed regarding the mechanical lifts. The Maintenance Director stated the facility had six mechanical lifts, which were all checked monthly. He stated as part of the facility's capital expenditure budget, the mechanical lifts were replaced at the rate of one to two per year, and currently none of the machines in the facility was more than four years old. The Maintenance Director stated like any mechanical equipment, the lifts occasionally experienced a break down, although such an occurrence was rare. In reviewing the facility's work orders, the Maintenance Director stated it had been well over four months since he had most recently received notification of a mechanical lift in need of repair. The Maintenance Director stated the bend in the structures of the machines is a design feature for safety, and that the machines are built that way purposefully.

The surveyor observations of mechanical lift transfers revealed no identified concerns.

Review of the facility's accident and incident reports revealed no incidents related to the malfunction of the vital signs machines or the mechanical lifts.

There were no documented grievances on file at the facility regarding malfunction in either the vital signs machines or the mechanical lifts.

There were no concerns identified with either the vital signs machines or the mechanical lifts for the sampled residents.

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



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August 8, 2014

Todd "Shane" Bell, Administrator
Kindred Nursing & Rehabilitation - Nampa
404 North Horton Street
Nampa, ID 83651-6541

FILE COPY

Provider #: 135019

Dear Mr. Bell:

On **July 11, 2014**, a Complaint Investigation survey was conducted at Kindred Nursing & Rehabilitation - Nampa. Lauren Hoard, R.N., Nina Sanderson, L.S.W., Linda Kelly, R.N. and Linda Hukill-Neil, R.N. conducted the complaint investigation.

The survey team reviewed the record of the identified resident, which included; physician's progress noted, telephone orders and nursing progress notes, as well as records for twelve other sampled residents.

Additionally, four other residents were sampled for oxygen use.

The team observed two meal services and reviewed the facility's dietary spreadsheets for both no added salt and two gram sodium limitation diets. A medication pass task was performed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006434

ALLEGATION #1:

The complainant stated an identified resident did not receive oxygen or cardiac medications for hours after admission.

Todd "Shane" Bell, Administrator
August 8, 2014
Page 2 of 3

FINDINGS #1:

The identified resident received medications before being discharged from the hospital. The resident was admitted to the facility late in the afternoon with no medications ordered until bedtime. The identified resident received oxygen in the hospital, but the oxygen was discontinued prior to transfer to the facility.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated an identified resident was gaining one to one and a half pounds per day. The complainant said the facility was aware of this but did not notify the physician or otherwise act on the information. The complainant said when the resident was seen at the cardiologist on April 1, 2014, he required intravenous diuretic medication two days in a row to reduce his edema.

FINDINGS #2:

The identified resident was weighed daily by the facility and did show a slight weight gain each day between March 28, 2014 and April 1, 2014. However, the weight gain did not reach the parameters of requiring physician notification as indicated by the Congestive Heart Failure clinic, which was responsible for managing the resident's newly diagnosed congestive heart failure. Additionally, the facility notified the resident's primary care physician of cardiac concerns on March 28, 2014.

The resident, who was alert, oriented and able to speak on his/her own behalf, was offered the opportunity to transfer to the emergency room at the acute care hospital for evaluation but elected to remain in the facility if his/her condition could be managed in that setting.

The resident's primary care physician provided new orders to the facility to manage the resident's condition until his/her appointment with the Congestive Heart Failure clinic on April 1, 2014. The resident's primary care physician also provided orders to the facility consistent with the resident's expressed wishes as to parameters that would indicate the resident's condition could not be managed in the facility and the resident should be sent to the emergency room. The resident's condition was managed in the facility within those parameters until the resident was seen at the Congestive Heart Failure Clinic, where he/she received intravenous diuretics on April 1 and April 2, 2014.

Todd "Shane" Bell, Administrator
August 8, 2014
Page 3 of 3

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated the facility did not follow the resident's cardiac diet or fluid restrictions as determined in the cardiologist's office on April 1, 2014.

FINDINGS #3:

The resident's diet, prior to the appointment with the Congestive Heart Failure clinic on April 1, 2014, had been for a "No Added Salt" diet with no other dietary or fluid intake restrictions, which was provided to the resident. After the April 1, 2014 appointment, the resident returned with a new order for a sodium restriction of 1,500 to 2,000 milligrams per day, as well as a one and one-half liter per day fluid restriction. A facility communication was sent to the dietary department on April 1, 2014, with this change.

Additionally, the facility was monitoring the resident's fluid intakes, which did not exceed the restriction ordered at the April 1, 2014 appointment.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser". The signature is written in a cursive, slightly slanted style.

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

LKK/dmj