



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 2125 6133

September 22, 2014

David D. Farnes, Administrator
Kindred Nursing & Rehabilitation - Aspen Park
420 Rowe Street
Moscow, ID 83843-9319

Provider #: 135093

FILE COPY

Dear Mr. Farnes:

On **September 12, 2014**, a Recertification and State Licensure survey was conducted at Kindred Nursing & Rehabilitation - Aspen Park 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

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 **October 6, 2014**. Failure to submit an acceptable PoC by **October 6, 2014**, may result in the imposition of civil monetary penalties by **October 27, 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.

David D. Farnes, Administrator
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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 **October 17, 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 **October 17, 2014**. A change in the seriousness of the deficiencies on **October 17, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 17, 2014** includes the following:

Denial of payment for new admissions effective **December 12, 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 **March 12, 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 Office or the State Medicaid Agency beginning on **September 12, 2014** and continue until substantial

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

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

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

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

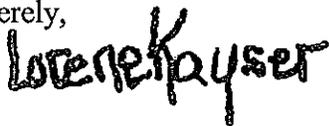
- BFS Letters (06/30/11)

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

This request must be received by **October 6, 2014**. If your request for informal dispute resolution is received after **October 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

LKK/dmj
Enclosures

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

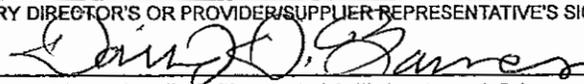
PRINTED: 09/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/12/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - ASPEN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 420 ROWE STREET MOSCOW, ID 83843
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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
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: Rebecca Thomas, RN, Team Coordinator Lauren Hoard, RN, BSN</p> <p>The survey team entered the facility on 9/8/14 and exited on 9/12/14.</p> <p>Survey Definitions: ADL = Activities of Daily Living AROM = Active Range of Motion BIMS = Brief Interview for Mental Status BLE = Bilateral Lower Extremities BUE = Bilateral Upper Extremities CM = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing DNS = Director of Nursing Services DX = Diagnosis HS = Hour of sleep LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment MG = Milligrams PO = By Mouth PRN = As Needed PROM = Passive Range of Motion QD = Every Day ROM = Range of Motion TAR = Treatment Administration Record TID = Three times per Day</p>	F 000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	
F 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS	F 154	F 154	10/17/2014

RECEIVED
NOV 18 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 11-3-14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 154	<p>Continued From page 1</p> <p>The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.</p> <p>The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to consider the risk identified with the use of psychoactive medications and the FDA Black Box Warning. This was true for 2 of 9 (#s 4 and 6) residents sampled for psychoactive medications. This deficient practice had the potential to cause harm when a resident's representative did not have an opportunity to make an informed decision regarding the potential risks associated with the Black Box Warning. Findings included:</p> <p>1. Resident #4 was admitted to the facility on 4/24/13 with multiple diagnoses which included paralysis agitans and dementia with behaviors.</p> <p>The medical record documented the facility was monitoring for visual hallucinations, anxious behaviors and depression.</p> <p>Resident #4's Physician's Orders for August 2014, documented an order for "Zyprexa (Olanzapine) 5 mg daily AM," with a start date of 4/14/14, for the diagnosis of dementia with behavioral disturbances. Physician's Orders for September 2014, documented an order for</p>	F 154	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <hr/> <p>F154 Continued from page 1</p> <p>Resident Specific</p> <p>Education on the black box warning information was provided to the resident or resident representative for residents #4 and #6. Updated consents were obtained and placed in the chart for the medications in question.</p> <p>Other residents</p> <p>A review of residents on medications that require education on the black box warning was conducted to confirm that the education had been provided and that the proper consents had been documented.</p> <p>Facility Systems</p> <p>A new physician order and post admit audit will be implemented to assure that patient/responsible party education has been provided as indicated; and that proper consents have been obtained for medications requiring black box warnings.</p>	

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F 154	<p>Continued From page 2</p> <p>"Zyprexa (Olanzapine) 2.5 mg daily PM," with a start date of 7/30/14, for the diagnosis of dementia with behavioral disturbances. Additionally, the medical record contained an order dated 9/8/14 to increase "Zyprexa to 5 mg for agitation (failed GDR) [gradual dose reduction]."</p> <p>The 2015 Nursing Drug Handbook documented: Zyprexa, page 1040: "Black Box Warning: Drug may increase risk of CV [cardiovascular] or infection-related death in elderly patients with dementia. Olanzapine isn't approved to treat patients with dementia-related psychosis."</p> <p>On 9/10/14 at 4:30 PM, the DNS was asked if the resident or their representative had been informed of the Black Box Warning for Zyprexa. The DNS stated the resident was on Zyprexa prior to admission and had a consent for the medication. When asked specifically if the resident's representative had been informed of the Black Box Warning the DNS stated, "I don't see it in here."</p> <p>2. Resident #6 was admitted to the facility on 11/17/10 and again on 8/19/11 with a diagnosis of Alzheimer's dementia with behavior disturbance.</p> <p>The medical record documented the facility was monitoring for irritability, verbal confrontations, unrealistic thoughts, intrusive wandering, exit seeking and confusion.</p> <p>Resident #6's Physician's Orders for September 2014, documented an order for, "Olanzapine TA 5 mg daily at noon" for the diagnosis of dementia with behavior disturbance, with a start date of 5/27/14.</p>	F 154	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Monitor</p> <p>The social service director will audit new physician orders for compliance once each week for 4 weeks, then biweekly for another 12 weeks beginning the week of October 6, 2014. The review will be conducted on a performance improvement (PI) audit tool. Any deficits will be addressed immediately. The PI committee will review the audit results and may adjust the frequency of the monitoring after 16 weeks as it deems appropriate.</p>	

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F 154	Continued From page 3 On 9/11/14 at 12:15 PM, the DNS was interviewed by the surveyor and asked if the resident or their representative had been informed of the Black Box Warning for Zyprexa. The DNS stated, "We have a consent but no Black Box Warning." NOTE: Federal guidance at F 154 documented, "'Informed in advance' means that the resident receives information necessary to make a health care decision, including information about his/her medical condition and changes in medical condition, about the benefits and reasonable risks of the treatment, and about reasonable available alternatives." On 9/11/14 at 1:00 PM, the Administrator and the DNS were informed of the lack of documentation regarding the Black Box Warning. The facility offered no further information.	F 154	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending 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	F 280	F 280 Specific Resident Resident #1's care plan has been updated to direct staff to monitor hours of sleep. Resident #5's care plan has been updated to include the specific exercises to be done for ROM. Other Resident Care plans for residents receiving hypnotic medication will be updated to include direction to monitor the hours of sleep. Care plans for residents receiving restorative nursing care will be updated to include the specific type of exercise to be done as	10/17/2014

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F 280	<p>Continued From page 4</p> <p>the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure care plans were revised to include monitoring hours of sleep related to the use of a hypnotic medication and to include direction to staff on specific range of motion exercises to perform with the resident and how often. This affected 2 of 9 (#s 1 & 5) sampled residents. This had the potential to result in harm if residents did not receive appropriate care due to lack of direction in the care plan. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 9/19/11 with multiple diagnoses which included insomnia.</p> <p>The most recent quarterly MDS assessment, dated 8/1/14, documented Resident #1 received hypnotic medication 7 out of 7 days.</p> <p>The September 2014 recapitulated Physician's Orders for Resident #1 documented, "RESTORIL (TEMAZEPAM) 15 MG Capsule 1 PO QHS Dx...INSOMNIA..."</p> <p>The Medication Record for Resident #1 documented, "DOCUMENT # OF HOURS SLEPT EACH SHIFT." The record documented numbers of hours slept each shift as directed.</p>	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>appropriate by the RNA.</p> <p>Facility Systems</p> <p>The interdisciplinary care team members were educated on including hours of sleep on the care plan. The restorative aides have been educated on utilizing Kindred's "Guide to Restorative Nursing". The RN designated for oversight of the RNA program will be responsible to develop the initial RNA care plan and to update the restorative care plans as indicated. The restorative nurse will meet routinely with the RNA's and update care plans as programs are added, deleted or updated for the benefit of the resident. Further, the DNS/Designee will validate that nursing staff update plans of care to reflect new orders received. New orders will be reviewed by IDT team in morning meeting 5 X Week to verify required care plan updates are in place.</p> <p>Monitor</p> <p>The DON or designee will monitor the care plans for residents with hypnotics to assure that they are complete including hours of sleep. Audits will be done weekly for 4 weeks and bi-weekly for 12 weeks beginning</p>	

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F 280	<p>Continued From page 5</p> <p>Resident #1's Care Plan documented a Focus of, "[Resident's name] uses Hypnotic medication [Restoril] Sleep disruption/Sleep deprivation," dated 10/16/13. The goals for the focus area documented, "[Resident's name] will experience minimal sleep disruption from environmental factors. Will sleep less than 3 hours daily and greater than 5 hours during night." The Interventions included, "Administer medications as ordered. See medication record. Monitor for effectiveness and side effects; Labs per order; Review with IDT [Interdisciplinary team] for GDR [Gradual Dose Reduction] as indicated; Try non pharmacological interventions [sic] for sleep medications..."</p> <p>The Care Plan did not direct staff to monitor hours of sleep for Resident #1.</p> <p>On 9/10/14 at 10:50 a.m., the DON was asked if Resident #1's care plan directed staff to monitor hours of sleep. After reviewing the resident's care plan, the DON stated, "It does not," and added the care plans usually do direct staff to monitor hours of sleep.</p> <p>2. Resident #5 was admitted to the facility on 9/28/06 with multiple diagnoses which included multiple sclerosis and paraplegia.</p> <p>The most recent quarterly MDS assessment for Resident #5, dated 7/28/14, documented:</p> <ul style="list-style-type: none"> * Intact cognition with a BIMS of 15; * Required extensive assistance with 2 or more people for bed mobility and transfers; * Required extensive assistance with 1 person for dressing and toilet use; and, * Range of motion impairment to bilateral lower 	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>the week of October 6, 2014. The DON or designee will review the care plans of residents receiving restorative nursing programs to see that the plan reflect specific exercises and frequency to be performed. The audits will be completed once weekly for 4 weeks, then bi-weekly for 12 weeks beginning the week of October 6, 2014. The PI committee will review the audit results monthly and may adjust the frequency of review after 16 weeks if deemed appropriate.</p>	

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F 280	<p>Continued From page 6 extremities.</p> <p>Resident #5's Care Plan documented a Focus of, "Self Care Deficit: Range of Motion r/t [related to] MS, Diabetes," dated 12/16/13. The Interventions included, "AROM for the following joints: BUE to maintain current mobility functioning. Cue resident to perform all motions slowly and smoothly; ROM Prog: Requires 15 minutes of nursing assistant time QD to physically or verbally cue the resident; PROM for the following joints: BLE to increase circulation and prevent contractures. Report verbal/non-verbal signs of pain."</p> <p>On 9/10/14 at 10:30 a.m., the DON and RNA #1 were interviewed about Resident #5 and the ROM. The DON said the resident was still on a restorative program and the exercises were cued. When asked what the ROM exercises were, the DON said she would have to look into it. RNA #1 said ROM was performed with the BUE with the use of a thera-band. She added she would perform the exercises with the resident 3 days per week and the rest of the time the resident was to perform the exercises on her own. The RNA said Physical Therapy was concerned with too much ROM with the BLE and had demonstrated the desired exercises to RNA #1. The RNA was asked how other staff performing ROM with the resident would know which exercises needed to be done since it was not described on the care plan. The RNA replied, "I see what you're saying," and provided a Training and Skills Practice sheet which documented the exercises to be performed for ROM which was located in a restorative binder and locked in a cabinet.</p>	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	

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F 280	<p>Continued From page 7</p> <p>The Training and Skills Practice sheet for Resident #5 documented, "[Change] to a min[imum] of 3 days [per] week for ROM [with] RNA," with a date of 4/29/14.</p> <p>Resident #5's Care Plan did not include the exercises to be performed for ROM, nor was the Care Plan updated to reflect a change in frequency from every day to 3 days per week.</p> <p>On 9/10/14 at 6:30 p.m., the Administrator and DON were informed of the care plan issues. No further information or documentation was provided.</p>	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to monitor the effectiveness of pain medication, ensure coordination of care between the facility and a local provider of dialysis, and ensure Physicians' orders were followed related to positioning a resident on their side. This was true for 2 of 6 (#3 & #4) sampled residents. These failures created the potential for residents to experience complications, discomfort and/or</p>	F 309	<p>F309</p> <p>Specific Resident</p> <p>Nurses were educated how to properly document effectiveness of pain medication. The nurses were educated on completing the dialysis log, the dialysis communication tool and ensuring the communication tool is returned from the center for Resident #3. Resident # 3 discharged on 9/17/2014. Staff was educated on following physician orders to position resident #4 on her side. Any resident refusals to comply will be properly documented.</p> <p>Other Residents</p> <p>Nurses will be educated on the proper documentation of resident response to being given PRN pain medication. This is to be</p>	10/17/2014

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F 309	<p>Continued From page 8 compromised medical status. Findings included:</p> <p>1. Resident #3 was admitted to the facility on 8/21/14 with diagnoses which included pelvic fracture, stenosis of left upper arm arteriovenous fistula and ESRD (End-stage renal disease).</p> <p>The resident's Admission MDS Assessment, dated 8/27/14, coded the following: *Cognition was severely impaired; *Functional areas of sleep and activities were effected by pain; *Experienced occasional pain with an intensity level of 5/10; and, *Was receiving dialysis treatment.</p> <p>a) The resident's Admission Orders, dated 8/20/14, documented an order for "Ultram 50 mg Q [every] 8 hr PRN pain."</p> <p>The resident's Medication Record for the month of September 2014, documented the resident received pain medication once daily on 9/1, 9/2, 9/3, 9/4, 9/5, 9/6 and 9/8. However, the effectiveness of the pain medication was only documented on 9/4 and 9/5/14.</p> <p>On 9/10/14 at 5:05 PM, the DNS was interviewed regarding the lack of documentation for the effectiveness of pain medication. When asked if there should be documentation of the effectiveness each time a pain medication was given, the DNS stated, "Yes".</p> <p>b) The resident's Admission Orders, dated 8/20/14, documented an order for: "Dialysis on M/W/F [Monday, Wednesday, Friday]" at a local dialysis center. At the time of</p>	F 309	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>done on the "pain monitoring flow sheet". Nurses will be educated on the use of the dialysis communication tool and log with any resident receiving dialysis. Nurses will be educated on documenting refusal of cares and communicating new orders.</p> <p>Facility Systems</p> <p>Nurses will be educated when processing new physician orders, to update the care plan and to communicate the change in the plan of care. IDT and PI agreed on the form to utilize for documentation PRN pain medication. It will be the pain monitoring flow sheet in the MAR.. This will simplify documentation and improve nursing compliance with proper documentation. Review and educate nursing staff on the policies and procedures for dialysis care. Educate staff regarding the use of the dialysis log and the dialysis communication tool on PCC. This form will be filled out and sent with future residents undergoing dialysis. The nurses will be responsible to document receipt of the form back upon return of the resident from dialysis. Nursing procedure and forms for dialysis will be kept in a dialysis binder for quick</p>	

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F 309	<p>Continued From page 9</p> <p>the survey, the resident should have visited the local dialysis center a total of eight sessions.</p> <p>The facility's "Dialysis Log" policy and procedure documented, "To record, monitor and identify changes in resident condition following a dialysis session. To record daily the access site care." The policy and procedure documented "Instructions for Use" which included:</p> <ul style="list-style-type: none"> *Complete resident demographics at the bottom of the page; *Check (4) the days the resident has dialysis; *Check (4) the type of access site; *Record Time under appropriate date column; *Complete and document vital signs under the appropriate date column *Record resident weight; *Initial completion of daily site care; *Observe Atrial Venous Fistula site, bruit or thrill present; *Observe the access site (Central Venous Catheter or Arteriovenous Fistula) for signs and symptoms of infection; *After the dialysis session check shunt site every hour for 6 hours for bleeding, pain, redness and swelling; *After completing each section enter initials; *Record initials and signature at the bottom of the page; and, *Upon completion of the form, place an X beside, "Place in resident medical record under the tab: Clinical Management." <p>Record review did not include documentation of a "Dialysis Log." The Treatment Record for the month of August 2014, did not include documentation of the information which the facility's policy and procedure required. The Treatment Record for the month of September</p>	F 309	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>reference. Nursing staff will be educated on process for discussing risk/benefit for residents and/or families when care is refused.</p> <p>Monitoring</p> <p>The DON or designee will utilize a PI tool to audit compliance with documentation for provision of PRN pain medication, dialysis communication, and dialysis log and physician direction for positioning of residents. Once weekly for 4 weeks then bi-weekly for 12 weeks beginning the week of October 6, 2014. The PI committee will review the audit results and may adjust the focus or frequency of monitoring after 16 weeks as deemed appropriate.</p>	

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F 309	<p>Continued From page 10</p> <p>2014, and only for the date of 9/8, included the following documentation: *Vital Signs after return from dialysis; *Initials of the nurse completing the Treatment Record; *Access site - s/sx (signs and symptoms) of infection present; and, *Post dialysis sessions - check shunt site/CVC (Central Venous Catheter) for bleeding, pain, redness, swelling every hour for 6 hours.</p> <p>The facility's "Dialysis Communication Record" policy and procedure documented the communication form provided information from the nursing center to the dialysis center and from the dialysis center to the nursing center for continuity of care. The policy and procedure documented instructions on the information the nursing center and dialysis center would each provide. Upon completion of the form, place an X beside, "Place in resident medical record under the tab: Clinical Management."</p> <p>Record review documented only two Dialysis Communication Records were found, dated 8/29 and 9/5/14, which had been filled out by the facility. The only information completed by the local dialysis center on the 8/29/14 communication record were the post vital signs. The local dialysis center did complete the pre-treatment weight, pre and post vital signs on the 9/5/14 communication record. However, neither the 8/29/14 or 9/5/14 records contained documentation by the dialysis center for the following: *List of medications given during/after the dialysis treatment; *List of foods and how much the individual ate/drank;</p>	F 309	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	

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F 309	<p>Continued From page 11</p> <p>*Special Instructions/Comments and/or changes in resident's condition; and,</p> <p>*Dialysis Center Nurse Signature and Date.</p> <p>On 9/10/14 at 5:05 PM, the DNS was interviewed regarding the lack of documentation for a resident on dialysis services. The DNS stated the resident's first day of dialysis after admission was 8/22/14 and the only Dialysis Communication Record documentation she could see in the medical record was for the dates of 8/29/14 and 9/5/14. However, the Dialysis Communication Record for today 9/10/14, was filled out and signed by the dialysis nurse. The DNS was asked to provide documentation the resident and access site were monitored after returning from dialysis as per their policy. The DNS stated she would check for additional information.</p> <p>On 9/11/14 at 11:25 AM, the DNS stated to the surveyor, "No more papers were found in regard to dialysis." Regarding the Dialysis Communication Record, the DNS stated the dialysis center has been educated, "this is a new process for them to send back paperwork." The DNS stated the dialysis center usually sent computerized documentation to facilities, but did not send the paperwork until requested that day.</p> <p>2. Resident #4 was admitted to the facility on 4/24/13 with multiple diagnoses which included paralysis agitans and dementia with behaviors.</p> <p>The resident's care plan for the goal of skin shear area on coccyx documented an intervention to "Encourage/assist resident to turn side to side while in bed. May use pillows for positioning."</p> <p>Record review documented an order from the</p>	F 309	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	

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F 309	<p>Continued From page 12</p> <p>resident's Physician, dated 8/14/14, "to position resident on her sides."</p> <p>Throughout the survey process from 9/8/14 through 9/11/14, the resident was observed in bed sleeping soundly on her back, with her mouth wide open and two pillows positioned under her neck and shoulders as follows: *9/8 at 4:14 PM; *9/9 at 7:50 AM, 9:40 AM, 10:15 AM, 2:00 PM, & 3:25 PM; *9/10 at 10:15 AM & 3:50 PM.</p> <p>On 9/10/14 at 4:30 PM, the DNS was interviewed regarding the resident's care plan intervention to assist resident to turn side to side while in bed and the Physician's order to position the resident on her sides. The DNS stated the resident had fragile skin, was on hospice services and the hospice nurse had arranged for the doctor's order to position the resident on her side. The DNS stated the resident refused to be on her side, however, the surveyor explained there was no documentation in the medical record for refusal of care. When asked for documentation of refusals, the DNS stated she would check into it.</p> <p>On 9/11/14 at 11:00 AM, the DNS stated, "I looked through the progress notes and did not find where the resident refused to lay on her side. I could only find where she was restless and crawling out of her bed."</p> <p>On 9/11/14 at 1:00 PM, the Administrator and DNS were made aware of the above concerns for monitoring the effectiveness of pain medication, lack of dialysis communication between the facility and providers of dialysis and aftercare for a resident who returned from dialysis, and failure</p>	F 309	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	

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F 309	Continued From page 13 to follow a physician's order to position a resident on their side. No further information was provided by the facility.	F 309	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to provide adequate monitoring of antidepressant medication to prevent duplicate therapy. This was	F 329	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> F - 329 Resident Specific Resident #6 physician has been asked to clarify the rationale for the use of multiple medications of the same class. Updated orders and diagnosis for the medications will be obtained. Other residents Resident medication profiles have been reviewed for duplications of anti-depressant therapy. Facility Systems Pharmacist will continue monthly medication review for all residents including identification of possible duplicate anti-depressant drug therapy. Nursing will be educated on identifying duplicate anti-depressant therapy within the same therapeutic class and alerting the IDT team as appropriate. For example the admitting nurse will review for possible duplication of anti-depressant therapy upon admission. Further a new physician order and post admit audit will be implemented to assure that newly admitted residents with	10/17/2014

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F 329	<p>Continued From page 15</p> <p>therapeutic effects...Documentation is necessary to clarify the rationale for and benefits of duplicate therapy and the approach to monitoring for benefits and adverse consequences...Use of two or more antidepressants simultaneously may increase risk of side effects; in such cases, there should be documentation of expected benefits that outweigh the associated risks and monitoring for any increase in side effects."</p> <p>Record review documented a Consultation Report, dated 1/28/14, where the resident's Physician clarified the indication for the use of Effexor and Trazodone as depression. A Consultation Report, dated 4/14/14, documented the pharmacist asked the Physician to, "Please re-evaluate the PRN order for Trazodone, perhaps discontinuing its use." The pharmacist documented the "Rationale for Recommendation - Intermittent PRN antidepressant use not only increases risk for adverse events and withdrawal syndrome, but also decreases the likelihood that antidepressant therapy will achieve its desired therapeutic effect. If your assessment identifies that antidepressant therapy may be indicated, please consider administering this or an alternative antidepressant therapy on a routine basis. If however, PRN therapy is to continue, it is recommended that a) the Prescriber document an assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual; and b) the facility interdisciplinary team ensure ongoing monitoring for effectiveness and potential adverse consequences." The Physician responded by placing a check mark beside the column which documented, "I decline the recommendation(s) above and do not wish to implement any changes due to the reasons below. Rationale: Use for</p>	F 329	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	

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F 329	Continued From page 16 behaviors." On 9/11/14 at 12:15 PM, the DNS was interviewed regarding the use of duplicate therapy. The surveyor asked if there was justification by the Physician for duplicate therapy for the diagnosis of depression. The DNS presented the Consultation Report, dated 4/14/14, in which the Pharmacist recommended the "PRN order for Trazodone be re-evaluated and perhaps discontinuing it's use." The DNS pointed out the Physician had written, "use for behaviors." The DNS stated, "This is the only documentation we have regarding duplicate therapy." The facility did not have the following documentation: *an assessment of risk versus benefit of the necessity for three antidepressants; *to clarify the rationale for and benefits of duplicate therapy; and, *of monitoring the benefits and adverse consequences of three antidepressants. On 9/11/14 at 1:00 PM, the Administrator and DNS were made aware of the concern regarding duplicate therapy. No further information was provided by the facility.	F 329	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
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	F 371	F 371 Resident Specific/Other Residents Food service employees, activities and all other employees will be educated on the proper use of hair restraints such as hats, hair coverings or beard nets, and clothing that covers body hair to keep their hair from contacting exposed food etc.	10/17/2014

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

PRINTED: 09/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/12/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - ASPEN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 420 ROWE STREET MOSCOW, ID 83843
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F 371	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure food was prepared in a sanitary environment. This had the potential to affect 9 of 9 (#s 1-9) sampled residents and any resident who ate their meals in the facility. This created the potential for cross-contamination of food and exposed residents to potential sources of pathogens. Findings included: On 9/8/14 at 1:40 PM, during the initial tour of the kitchen the Dining Services Manager was observed to have a beard which was not covered with a beard restraint. Additionally, the Activities Director (AD) was observed to come in to the kitchen, without a hair net, to deliver a dirty dish. The 2009 FDA Food Code, Chapter 2, Part 2-4, Hygiene Practices, Hair Restraints, subpart 402.11, Effectiveness, indicates, "(A) Except as provided in ¶ (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. (B) This section does not apply to food employees such as counter staff who only serve beverages and wrapped or packaged foods, hostesses, and wait staff if they present a minimal risk of contaminating exposed</p>	F 371	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Facility Systems</p> <p>Hair and beard nets have been situated at the entrance to the dietary area to be readily available for use by all staff as needed. An area has been outlined in tape on the floor beyond which staff cannot proceed without a hair or beard net, but allows for dirty dishes to be dropped off. All staff will be in-serviced regarding the above designated areas and requirements for compliance with food code.</p> <p>Monitoring</p> <p>The ED or designee will complete audits of hair/beard restraint use once per week for four weeks and then bi-weekly for 12 weeks beginning the week of October 6, 2014 to assure compliance with proper use of hair restraints in the food preparation areas of the dietary department. The PI committee will review audit results and may adjust the frequency of monitoring after 16 weeks as deemed appropriate.</p>	

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F 371	<p>Continued From page 18</p> <p>food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles."</p> <p>On 9/8/14 at 2:00 PM, the Dining Services Manager stated, "I have the beard restraints but I didn't wear it. I'm going to shave my beard."</p> <p>On 9/8/14 at 2:10 PM, the AD was interviewed in the presence of the Dining Services Manager. When asked about not wearing a hair net in the kitchen, the AD stated, "Am I suppose to wear a hair net when I walk in?" The Dining Services Manager explained to the AD that when walking in the kitchen past the "invisible line" (on the floor in the kitchen) that he should wear a hair net.</p> <p>On 9/8/14 at 4:25 PM, the Administrator was made aware of the beard and hair net concerns. No further information was provided by the facility.</p>	F 371	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	
F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State;</p>	F 514	<p>F514</p> <p>Resident Specific The nurses who did not document the completion of treatments were educated on the proper documentation of treatment for resident # 5.</p> <p>Other residents Treatment records for the last 30 days will be audited to identify other affected residents.</p> <p>Facility Systems</p>	10/17/2014

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F 514	<p>Continued From page 19 and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices to ensure records were complete and accurate. This was true for 1 of 9 (#5) sampled residents when there was incomplete documentation on the TAR related to skin care. This deficient practice increased the risk for medical decisions to be based on incomplete or inaccurate information and increased the risk for complications due to inappropriate care or interventions. Findings included:</p> <p>Resident #5 was admitted to the facility on 9/28/06 with multiple diagnoses which included multiple sclerosis and paraplegia.</p> <p>The most recent quarterly MDS assessment for Resident #5, dated 7/28/14, documented: * Intact cognition with a BIMS of 15; * Required extensive assistance with 2 or more people for bed mobility and transfers; * Required extensive assistance with 1 person for dressing and toilet use; * No pressure ulcers but at risk for pressure ulcers; and, * Skin treatments: Applications of ointment/medications other than to feet.</p> <p>The September 2014 recapitulated Physician's Orders for Resident #5 documented, "TX [Treatment] TO BUTTOCKS: CLEAN WITH NS [Normal Saline], PAT DRY WITH 2X2, APPLY</p>	F 514	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>The nurses will be educated on proper documentation of treatments on the TAR records. Nurses will be required to assure that their TAR sheets are properly completed by the end of their shift. A shift to shift reporting log indicating TAR review will be completed at each shift change. The RCM will spot check random sample of resident TAR's <i>three times per week.</i></p> <p>Monitoring</p> <p>The DON or designee will use PI tool to audit compliance once per week for 4 weeks and bi-weekly for 12 weeks beginning on October 6, 2014. The PI committee will monitor the results and may adjust the frequency as necessary after 16 weeks as deemed appropriate.</p>	

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F 514	<p>Continued From page 20 ANTIFUNGAL CREAM, NYSTATIN POWDER, BARRIER CREAM TOPICAL TID."</p> <p>The June and July 2014 Treatment Records for Resident #5 documented the aforementioned Physician's Order. The LN's were to document their initials in the boxes for AM, PM and HS shifts. On 6/9/14 and 6/27/14, boxes for the AM shift were blank. On 6/10/14, 6/21/14, 6/27/14 and 6/28/14, boxes for the PM shift were blank. On 6/3/14, 6/4/14, 6/6/14, 6/7/14 and 6/21/14, boxes for the HS shift were blank. In July, two boxes were left blank which included the AM shift on 7/19/14 and the HS shift on 7/26/14.</p> <p>On 9/10/14 at 10:30 a.m., the DON was interviewed regarding the blank boxes on the Treatment Record for Resident #5. When asked what the blank boxes meant, the DON stated, "That means the nurses haven't charted. They should be charting."</p> <p>On 9/10/14 at 6:30 p.m., the Administrator and DON were informed of the incomplete Treatment Record. No further information or documentation was provided.</p>	F 514	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	

Bureau of Facility Standards

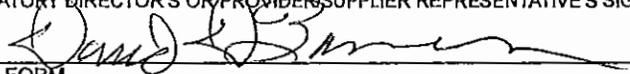
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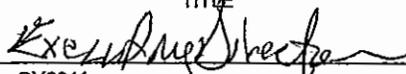
STREET ADDRESS, CITY, STATE, ZIP CODE
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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the State licensure survey of your facility. The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator Lauren Hoard, RN, BSN	C 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
C 119	02.100,03,c,iii Informed of Medical Condition by Physician iii. Is fully informed, by a physician, of his medical condition unless medically contraindicated (as documented, by a physician, in his medical record), and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research; This Rule is not met as evidenced by: Please refer to F-154 as it relates to black box warnings for psychoactive medications.	C 119	C 119 Please Refer to CMS 2567 - F154	10/17/2014
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)."	C 325	C 325 Please Refer to CMS 2567 - F371	10/17/2014

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



TITLE



(X6) DATE

11-3-14

Bureau of Facility Standards

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C 325	Continued From page 1 This Rule is not met as evidenced by: Please refer to F-371 as it relates to cleanliness.	C 325	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
C 781	02.200,03,a,iii Written Plan, Goals, and Actions iii. Written to include care to be given, goals to be accomplished, actions necessary to attain the goals and which service is responsible for each element of care; This Rule is not met as evidenced by: Refer to F280 as it relates to care plan revisions.	C 781	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> C 781 Please Refer to CMS2567 – F280	10/17/2014
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F-309 as it relates to to the facility providing the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being.	C 784	C 784 Please Refer to CMS2567 – F-309	10/17/2014
C 820	02.201,01,a 30-Day Review of All Meds a. Reviewing the medication profile for each individual patient at least every thirty (30) days. The attending physician shall be advised of drug therapy duplication, incompatibilities or contraindications. This Rule is not met as evidenced by:	C 820	C 820 Please Refer to CMS2567 – F-329 C881	10/17/2014

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C 820	Continued From page 2 Please refer to F-329 as it relates to duplicate therapy.	C 820	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Refer to F514 as it relates to complete documentation.	C 881	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> C 881 Please refer to CMS2567 F-514	10/17/2014