



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7012 1010 0002 0836 2045

November 19, 2013

MaryRuth Butler, Administrator
Kindred Nursing & Rehabilitation - Mountain Valley
601 West Cameron Avenue
Kellogg, ID 83837

Provider #: 135065

Dear Ms. Butler:

On **November 7, 2013**, a Recertification and State Licensure survey was conducted at Kindred Nursing & Rehabilitation - Mountain Valley by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be 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 Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in

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the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 2, 2013**. Failure to submit an acceptable PoC by **December 2, 2013**, may result in the imposition of civil monetary penalties by **December 23, 2013**.

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

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

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

- The administrator must sign and date the first page of both the federal survey report, Form

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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 **December 12, 2013 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **December 12, 2013**. A change in the seriousness of the deficiencies on **December 12, 2013**, may result in a change in the remedy.

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

Denial of payment for new admissions effective **February 7, 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 **May 7, 2014**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

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

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Regional Office or the State Medicaid Agency beginning on **November 7, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **December 2, 2013**. If your request for informal dispute resolution is received after **December 2, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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: 11/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHAB - MOUNTAIN VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST CAMERON AVENUE KELLOGG, ID 83837		
(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: Amy Jensen RN, BSN, Team Coordinator Sherri Case LSW, QMRP Nina Sanderson LSW Susan Gollobit RN The survey team entered the facility on Monday, 11/04/13, and exited on Thursday, 11/07/13.</p> <p>Survey Definitions:</p> <p>ADL = Activities of Daily Living CAA = Care Area Assessment CNA = Certified Nurse Aide DON-DNS = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment CDDO = Clinical Director of District Operations ADNS = Assistant Director of Nursing Staff</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> <p style="text-align: center;">RECEIVED NOV 29 2013 FACILITY STANDARDS</p>		
F 242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 242	<p>F242</p> <p>I. Resident #2 was interviewed on November 8, 2013, and his care plan was updated with his religious and dietary preferences. His tray card was reviewed for accuracy ensuring the facility is honoring Resident #2 meal choices.</p> <p>II. Residents of the facility have been interviewed regarding meal preferences and dietary tray cards have been updated.</p> <p>III. Dietary staff were educated about the importance of reviewing each resident's meal preferences on their dietary tray cards. Staff were educated on how to review the dietary tray card during meal service to ensure the facility is honoring resident meal choices.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marybeth Butler, Executive Director TITLE: _____ (X6) DATE: 11/27/13

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

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F 242	<p>Continued From page 1</p> <p>Based on observation, record review, staff and resident interview, it was determined the facility failed to ensure meals provided met a resident's religious preference. This affected 1 of 9 residents (Resident #2) whose records were reviewed. The facility's failure to ensure a resident's meal choices were recognized created the potential for reduced self esteem when his meal preference, related to religion choices, were not honored. Findings included:</p> <p>Resident #2 was admitted to the facility on 4/15/13 with diagnoses which included sacral and lateral decubitus (pressure ulcers), multiple sclerosis, and protein calorie malnutrition.</p> <p>Resident #2's 4/22/13 annual MDS and 7/14/13 quarterly MDS coded the resident was cognitively intact.</p> <p>On 11/6/13 at 8:00 a.m. CNA #5 was coming out of Resident #2' room with his breakfast tray. The surveyor stated the resident had eaten everything but his sausage. CNA #5 replied "he doesn't do sausage." The surveyor asked for the meal instruction/choice on the tray which included the resident disliked ham, bacon and sausage.</p> <p>On 11/6/13 at 8:15 a.m. the dietitian was shown the meal card and stated the resident should not have been served the sausage.</p> <p>On 11/6/13 at 8:30 a.m. Resident #2 stated he did not eat sausage due to "religious preference and trichinosis." The resident stated sausage was only served at breakfast but he was served sausage frequently.</p> <p>The DON and the Administrator were informed of</p>	F 242	<p>IV. The Certified Dietary Manager (CDM) and Executive Director (ED) are to oversee. The CDM, ED, or Designee will perform rounds and audits for compliance three times a week for one month, then twice a week for two months, then continue monitoring through individual resident satisfaction interviews every three to six months. Audits will begin on December 9, 2013. Findings will be reported to the facility's Performance Improvement Committee for further recommendations.</p> <p>V. 12/12/13</p>	

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F 242	Continued From page 2 the above concern on 11/6/13 at 5:30 p.m. On 11/7/13 at 9:10 a.m. the Administrator stated she did not believe the resident was served sausage often. The Administrator stated she had recently met with the resident and he had no dietary complaints. The Administrator also commented the resident had not lost weight. On 11/11/13 a fax was received from the facility documenting the resident was offered opportunities to express dietary concerns 4 times in 10/13 and did not express concerns. Additionally the resident was capable of expressing concerns. A resident interview form included in the fax documented in section K "Food Quality" the food tasted good, looked appetizing and was served at the proper temperature. NOTE: The survey did not ask if the resident was ever served a food he had identified as disliked on his food preference card or if the food he was served met his religious preferences.	F 242			
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:	F 309			

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F 309	<p>Continued From page 3</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure continuity of care for residents receiving dialysis services. This was true for 1 of 1 sampled resident (#10) reviewed for dialysis. This created the potential for harm if the resident did not receive the care and/or services based on their current needs. Findings included:</p> <p>Resident #10 was admitted 4/30/13 and readmitted on 10/10/13 with diagnoses which included end stage renal disease.</p> <p>Review of Resident #10's most recent Admission MDS assessment, dated 10/17/13, documented the resident was cognitively intact and received dialysis services.</p> <p>Resident #10's 10/10/13 Care Plan (CP) for End Stage Renal Failure included interventions of :</p> <p>Complete dialysis log record on return from dialysis Dialysis Center on Monday, Wednesday and Friday Monitor/assess site (right upper chest) upon return from dialysis for bleeding, redness, swelling pain and non-functioning. Notify physician as needed.</p> <p>*NOTE: The Care Plan instructed staff to only assess the resident when he returned from dialysis. The implementation section did not include to assess the access site on the days the resident did not go to dialysis (Saturday, Sunday, Tuesday or Thursday).</p> <p>Additionally the care plan did not include:</p>	F 309	<p>F309</p> <p>I. Resident #10's care plan has been updated to reflect assessment, care of the dialysis access site, signs and symptoms of possible complications, and communication with the Dialysis Center of resident issues and/or concerns. The Dialysis Communication Record is now being utilized for communication between the facility and the Dialysis Center. The Dialysis Log is being completed after each dialysis appointment with applicable information. In addition, resident #10 has been educated on the importance of the Dialysis Communication Record for communication between the facility and the Dialysis Center.</p> <p>II. The facility currently has no other residents receiving dialysis.</p> <p>III. The facility's protocols, forms, and care plan for dialysis have been reviewed with the licensed nursing staff. In addition, education was provided regarding the various types of dialysis access sites, care of access sites, signs and symptoms of complications related to dialysis and access sites, and the importance of communication with the Dialysis Center about any resident concerns. Newly hired Licensed Nursing staff will be oriented during facility orientation.</p> <p>IV. The Director of Nursing (DNS) or Designee is responsible to oversee. The DNS or designee will perform chart audits for compliance three times a week for one month, then twice a week for two months. Audits will begin on December 9, 2013. Findings will be reported to the facility's Performance Improvement Committee for further recommendations.</p> <p>V. 12/12/13</p>		

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F 309	<p>Continued From page 4</p> <ul style="list-style-type: none"> *To communicate with the dialysis center regarding any concerns regarding the resident prior to dialysis i.e. the resident's blood pressure or weight prior to leaving the facility. *To notify the dialysis center of any concerns when the resident returned to the facility. *To check for complaints of numbness *To keep the access clean and dry <p>On 11/6/13 at 2:45 p.m. the surveyor asked for communication between the facility and the dialysis center. The CDDO stated staff had not been trained on the use of the electronic form for communication between the dialysis provider and the facility.</p> <p>The resident's 10/13, 11/1/13 and 11/4/13 Dialysis Log (DL) documented the resident was to go to dialysis on Monday, Wednesday and Friday. The DL instructions were to only complete the form when the resident returned from dialysis. The DL had areas to document the resident's temperature, pulse, respirations (vital signs), and weight. The access site was to be checked for signs and symptoms of infection. The DL included to check the bruit/thrill (blood flow), bleeding, pain or redness and swelling.</p> <p>Note: The DL section for the resident's weight were all left blank. Additionally there was not any information documented for 10/11/13 (Friday), 10/14/13 (Monday) or 10/16/13 (Wednesday).</p> <p>Resident #10's Progress Notes from 10/10/13 -11/5/13 documented the following: 10/14/13 - Continues on dialysis three times a week - written by the Certified Dietary Manager (CDM). No sign of glycemic reactions or distress from dialysis - written by the licensed nurse (LN).</p>	F 309			

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F 309	<p>Continued From page 5</p> <p>10/15/13 - Dialysis port to right chest intact-no signs or symptoms of infection. Goes to dialysis 3 times a week-LN.</p> <p>10/16/13 - The resident returned from dialysis with skin "Pale, warm and dry. The dialysis catheter dressing was intact and no bleeding noted. Appears very fatigued and say (sic) he feels 'awful.' Sleeping on top of bed at this time." LN.</p> <p>10/23/13 - Weight varies related to dialysis. "Current weight 118.6 down from 121.7 in one week. Will continue to monitor." LN.</p> <p>10/25/13 - "Pt (patient) returned from dialysis pale and weak. Pt's blood pressure (BP) was 64/57 encouraged pt to lay down and gave him fluids. Rechecked BP in 30 min it was 76/56. Pt stated he was feeling better. LN.</p> <p>10/28/13 - "Resident returned from dialysis with acute nausea and malaise. Zofran 4 mg administer for GI (stomach) upset with minimal relief....Did take Oxycontin 40 mg, Protonoix and Lyrica at HS (hour of sleep). Stated he felt a little better but refused any p.o. (oral) intake." LN.</p> <p>10/29/13 - "Pt went to dialysis yesterday and was given a glove that a staff member had adapted for right hand. Pt had been wearing it for about 6 hours. Removed the glove and noted that along his posterior knuckles, a indented line, red in color, nonblanchable. Skin is intact. This area is from a seam on the glove..." LN.</p> <p>10/31/13 - "Requested to receive reports from dialysis to include labs/weights assist with tracking weight/labs. May benefit with Nephrovite q/d (every day) overall wellness/healing." RN.</p> <p>Note: The Progress Notes did not document the dialysis center had been notified the days the resident returned from dialysis when he was nauseated, or the problem with the glove</p>	F 309			

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F 309	Continued From page 6 provided by dialysis. There was no documentation the dialysis center had been asked about the Nephrovite. On 11/6/13 at 3:00 p.m. the Administrator stated the facility did not have a written agreement with the dialysis center. On 11/6/13 at approximately 4:30 p.m. LN #8 stated she did not remember the signs or symptoms of septic shock but could "go on line." LN #8 also stated she had not received training regarding Resident #10's shunt but other nurses may have been trained.	F 309			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	F431 I. Resident #12's order for the medication was already discontinued prior to survey exit, therefore, no further action was needed for this resident. Resident #16 – the pharmacy was notified of the discontinuation of the parameters for blood pressure and pulse on two physician's orders. New pharmacy labels were made and applied to the medication cards to match the physician's orders. LN #1 was identified and educated specifically regarding Facility Protocol for medication administration. II. An audit was performed to verify that all physicians' orders matched the pharmacy drug card label for all residents.		

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F 431	Continued From page 7 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview it was determined the facility did not ensure: *Medications were stored in locked compartments, *Medication dispensing cards were accurately labeled, and *A doctor's order was clarified when it lacked a dosage. This was true for 2 of 16 sampled residents (#s 12 & 16) and all residents in the 100 and 200 wings. The deficient practice had the potential to cause more than minimal harm for a wandering or confused resident who may ingest medication left unattended on the top of a medication cart or misuse items located in the unlocked cart. Resident #12 was prescribed a medication that did not have a dosage, and 2 of Resident #16's medication dispensing cards had instructions on them that conflicted with the actual doctor's order. This placed both residents at risk for untoward side effects of being under or over medicated Findings included:	F 431	III. The facility's protocols for complete physicians' orders and need for clarification, accurate labeling of drugs/biologicals, comparison of drug labels with MARS and permitting only authorized personnel access to medication and the medication cart were reviewed with input from the PharMerica Pharmacy Consultant. The licensed nursing staff have been re-educated regarding these protocols. Newly hired licensed nursing staff will be educated during facility orientation of these protocols. IV. The DNS or designee is responsible to oversee. The DNS or designee will perform rounds for compliance three times a week for one month, then twice a week for two months to ensure compliance with medications/biologicals being secured and the medication carts locked. In addition, checks will also be performed at this time to check for matching of physicians' orders and pharmacy labels. Audits will begin on December 9, 2013. Findings will be reported to the facility's Performance Improvement Committee for further recommendations. V. 12/12/13		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHAB - MOUNTAIN VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST CAMERON AVENUE KELLOGG, ID 83837		
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F 431	<p>Continued From page 8</p> <p>1. On 11/5/13 at 4:25 PM the surveyor observed an unattended medication cart in the 200 hall. On the top of the cart was the medication Copaxone injectable. The 4 drawers on the right of the cart were noted to be left unlocked and contained the following:</p> <ul style="list-style-type: none"> *Drawer 1: Straws, spoons, and medication cups. *Drawer 2: Miscellaneous Diabetic supplies to include: insulins, syringes, blood glucose finger stick supplies. *Drawer 3: Locked box *Drawer 4: Cup supplies. <p>The surveyor was at the cart for approximately 5 minutes when LN #1 came out of room #204 by where the cart was parked. LN#1 stated, "I thought [Resident] had fell so I went in to check on her." LN#1 also stated the Copaxone had been on the cart for 10 minutes to get warm.</p> <p>On 11/5/13 at 4:53PM the surveyor observed LN #1 leave 2 vials of insulin, Levemir and Novolog, on top of the medication cart unattended while the surveyor accompanied LN #1 into room 105B to administer the insulin injections that LN#1 had prepared from the insulin vials. NOTE: The insulins were left on the top of the medication cart unattended for approximately 5 minutes.</p> <p>On 11/7/13 at 11:15AM the surveyor spoke with the DNS about the medication pass and the observations. The DNS stated she had already heard about the medication cart being left unlocked from LN#1 and the DNS agreed with the</p>	F 431			

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F 431	<p>Continued From page 9 deficient findings.</p> <p>2. Resident #12 had a doctor's order for "Mucinex BID [twice a day] x [for] 10 days," dated 10/16/13. The order did not include the number of tablets to be given. The October 2013 Medication Administration Record documented the resident was to receive the medication "Mucinex [1] tab [tablet]/cap [capsule] bid x 10 days." The MAR did reveal that the medication had been given from 10/16/13 through 10/27/13. NOTE: An order to clarify the dosage of this medication and the number of tablets to be dispensed was not found in the doctor's orders, and was not clear on the MAR.</p> <p>On 11/7/13 at 9:40 AM the surveyor asked the DNS about the order clarification and the DNS stated "I will check into it."</p> <p>On 11/7/13 at 11:35 AM DNS provided the surveyor with a letter from the [Local Pharmacy] dated 11/07/2013 which stated "....The following conventions are normal dispensing practices when the following orders are placed: Mucinex will be dispensed as Mucinex 600mg [milligrams]...." At 11:40 AM the surveyor asked the DNS if they had a formulary for their facility that stated these parameters were acceptable for the residents of their facility. The DNS stated they did not.</p> <p>3. On 11/7/13 at 7:28 AM while observing the medication pass the surveyor observed LN#2 to dispense medications to Resident #16. The medication dispensing card had directions for: "Metoprolol 50mg 1 q [every] day Hold if SBP[systolic blood pressure] <[less than]100 or HR [heart rate] < 55," and "Losartan 25 mg 1 tab</p>	F 431			

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F 431	<p>Continued From page 10</p> <p>[tablet] q day Hold if SBP <105." When LN #2 gave the medication to the resident, the LN did not take the blood pressure or heart rate of the resident. The surveyor asked LN#2 if she had previously checked the resident's blood pressure or heart rate. LN#2 stated, "No." The MAR was observed to lack documentation of either of these. LN#2 then stated, "I was thinking I didn't have to, but when you asked about them then I wondered."</p> <p>On 11/7/13 at 8:00 AM when reviewing the chart the surveyor observed the doctors order's for Resident #16. The orders for the medications in question were written as: "Toprol XL [extended release](Do not crush) 50 mg po [by mouth] q [every] day for HTN [hypertension] and "Cozaar (Losartan Potassium) 25 mg po q day." NOTE: Toprol is a generic name for Metoprolol.</p> <p>On 11/7/13 at 8:10 AM the surveyor interviewed the DNS on the orders and the facility's policy on medication orders. The DNS stated it was odd that the medication card stated the need for the blood pressure and heart rate checks as the order did not. The surveyor presented the conflicting orders, and the DNS agreed that there was a problem. The DNS was not aware that the parameters were on the medication dispensing cards. The DNS stated they do have an LN that spends about 6 hours checking the medication dispensing cards each month when they come in. The DNS stated the LN probably checks the name of the resident, the medication, the dose of the medication, and when it expires, but not the directions for giving it.</p> <p>On 11/7/13 the DNS provided August 2013 Recapitulation Doctor orders with the blood</p>	F 431			

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F 431	Continued From page 11 pressure and heart rate parameters being discontinued during the month of August. [NOTE: The pharmacy had labeled the medication with instructions that had been discontinued in August.]	F 431			
F 441 SS=E	On 11/7/13 at 2:00 PM the Administrator and the DNS were informed of the surveyor's findings. The facility offered no further information. 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	F 441	F441 I. LN #4 was immediately re-educated on the importance of thorough and proper hand washing technique. II. Resident's located on the 300 hall that LN #4 provided care for, assessed and no adverse effect noted. III. The facility's protocols for hand washing was reviewed with staff providing resident care with emphasis on cuts on hands and fingers. Staff providing direct resident care were observed performing the hand washing technique based on the facility's hand washing checklist. IV. The Staff Development Coordinated (SDC) or designee is responsible to oversee. The SDC or designee will perform rounds for compliance three times a week for one month, then twice a week for two months ensuring compliance with the facility's hand washing policy. These rounds will also include checking employees' skin for any skin issues on fingers and hands. Audits began on December 9, 2013. Findings will be reported to the facility's Performance Improvement Committee for further recommendations. V. 12/12/13		

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F 441	<p>Continued From page 12</p> <p>hands after each direct resident contact for which 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, staff interview and policy review, it was determined the facility failed to ensure staff performed handwashing in an accepted professional manner while performing resident care. This was true for all residents in the 300 hall. The deficient practice had the potential to cause more than minimal harm when LN#4 was observed to sanitize fingertips only of both hands after resident cares. Findings included:</p> <p>*The Facilities Hand Hygiene/Handwashing policy in the section: Alcohol-Based Hand Rub states, "8. Apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry."</p> <p>On 11/5/13 at 5:25PM LN#4 was observed to be passing medications to the residents in the 300 hall. LN#4 had Tubigrip covering both upper extremities from just below the elbows into her hands, to the base of her fingertips. There were also band aids on 3 fingers that covered the midsection of those fingers. LN#4 was observed to dispense medications into the medication cup and go into Room 301. When LN#4 came out of the room the surveyor observed the LN to put</p>	F 441			

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F 441	<p>Continued From page 13</p> <p>hand sanitizer from on top of the medication cart to the fingertips of her fingers and rub fingertips only together. LN#4 then went on to open the cart and dispense more medications.</p> <p>On 11/5/13 at 5:35PM the CDDO was asked about LN#4, the CDDO stated "I do not know anything about LN#4, but I will go find out."</p> <p>On 11/5/13 at 5:40PM the surveyors met with the CDDO, DNS, ADNS-Infection Control nurse, to discuss how LN#4 was performing hand washing technique, from the Infection Control standpoint, with the Tubigrips in place. The observation was presented to the staff in the interview. The ADNS stated LN#4 is sanitizing the hands and gets the fingers wet, the cover is not getting wet. When asked about the palm of the hand getting wet the ADNS then stated the cover is getting wet. When asked about the wet cover carrying bacteria, the CDDO stated, "I've watched her all day and it's dry." The ADNS-Infection Control nurse stated when LN#4 started she looked at the skin under the Tubigrips, but had not since. When asked whether the whole hand was getting washed the 3 staff in the room in unison stated "No."</p> <p>On 11/7/13 at 2:00PM the Administrator and the DNS were informed of the surveyor's findings. The facility offered no further information.</p>	F 441			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001520	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHAB - MOUNTAIN VA	STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST CAMERON AVENUE KELLOGG, ID 83837
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>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.</p> <p>The following deficiencies were cited during the annual State Licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Amy Jensen RN, BSN, Team Coordinator Sherri Case LSW, QMRP Nina Sanderson LSW Susan Gollobit RN</p>	C 000	<p>RECEIVED</p> <p>NOV 29 2013</p> <p>FACILITY STANDARDS</p>	
C 644	<p>02.150,01,a,i Handwashing Techniques</p> <p>a. Methods of maintaining sanitary conditions in the facility such as:</p> <p>i. Handwashing techniques.</p> <p>This Rule is not met as evidenced by: Please see F 441 as it pertains to handwashing.</p>	C 644	Refer to Plan of Correction for F441	
C 780	<p>02.200,03,a,ii Coordinated with Other Care Services</p> <p>ii. Developed in coordination with other patient/resident care services provided to the patient/ resident; This Rule is not met as evidenced by: Please refer to F309 as it related to coordination of care services between the facility and dialysis.</p>	C 780	Refer to Plan of Correction for F309	

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Marybeth Butler</i> Executive Director	TITLE _____	(X6) DATE 11/27/13
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