IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

July 13, 2015

Debbie Freeze, Administrator
Kindred Transitional Care & Rehabilitation - Lewiston
3315 8th Street
Lewiston, ID 83501-4966

Provider #: 135021

Dear Ms. Freeze:

On **June 19, 2015**, a survey was conducted at Kindred Transitional Care & Rehabilitation - Lewiston 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 an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided 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." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) 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 the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 27, 2015**. Failure to submit an acceptable PoC by **July 27, 2015**, may result in the imposition of civil monetary penalties by **August 17, 2015.**

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;

- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and

- 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.

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

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

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your

provider agreement be terminated on **December 19, 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, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; 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 **June 19, 2015** 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 non-compliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

  2001-10 Long Term Care Informal Dispute Resolution Process
  2001-10 IDR Request Form

This request must be received by **July 27, 2015**. If your request for informal dispute resolution is received after **July 27, 2015**, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

NINA SANDERSON, Supervisor
Long Term Care

NS/dmj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135021	A. BUILDING _____ B. WING _____	06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB - LEWISTON	3315 8TH STREET LEWISTON, ID 83501

(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	INITIAL COMMENTS The following deficiencies were cited during the Federal recertification and State licensure survey of your facility. The survey team entered the facility June 15, 2015 and exited June 19, 2015. The survey team included: Linda Kelly, RN, Team Coordinator Brad Perry, BSW, LSW and Becka Watkins, RN. This report reflects changes resulting from the Informal Dispute Resolution (IDR) process completed on 09/03/2015. Survey Definitions: ADL's = Activities of Daily Living BID = Twice a day BIMS = Brief Interview for Mental Status BM = Bowel Movement CAA = Care Area Assessment CNA = Certified Nurse Aide CVA = Cerebral Vascular Accident DDCO = District Director of Clinical Operations DON/DNS = Director of Nursing Services ER = Extended Release GI = Gastrointestinal IV = Intravenous MAR = Medication Administration Record LN = Licensed Nurse MD = Medical Doctor MDS = Minimum Data Set assessment MG = Milligrams PRN = As needed PO = By mouth Sub-Q.= subcutaneous TAR = Treatment Administration Record	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debbie Fleck — TITLE: Ex. Director — (X6) DATE: 07/24/2015

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

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F 000	Continued From page 1 TABS = Tablets UTI = Urinary Tract Infection	F 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Transitional Care and Rehabilitation does	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157	not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. F157 **Resident Specific** The ID team reviewed resident #__14, resident did not return to facility **Other Residents** The ID team reviewed other residents for timely family notification and found no other issues. Adjustments have been made as indicated. **Facility Systems** All licensed nurses are educated/reeducated to but not limited as to timely notification of family of resident's incidents and or change of condition.	8/17/15

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F 157	Continued From page 2 by: Based on staff interview and review of facility and hospital records, it was determined the facility failed to immediately notify the family of a change in condition for 1 of 14 sample residents (#14) who fell and sustained hip and wrist fractures and a large hematoma above the eye. Failure to notify the family in a timely manner created the potential for the resident to experience anxiety or emotional distress when the family was not given the opportunity to provide support and comfort or to assist the resident to make informed decisions about treatment options following emergency transport to a hospital for emergency care. Findings included: Resident #14 was admitted to the facility in 2010 and readmitted in 2011 with multiple diagnoses including cervical C2 vertebral fracture and subsequent paraplegia, morbid obesity and anxiety disorder. The most recent quarterly MDS assessment, dated 4/9/15, coded the resident as cognitively intact with a BIMS score of 15 and extensive 1 person assistance for bed mobility and transfers. The resident's care plan included the focus areas: * "Physical Mobility Impaired related to pain, obesity, unsteady gait, fatigue, weakness" revised in May 2013 - Interventions included, "Bed against wall..." initiated March 2011, "Bed mobility w [with]/extensive assist..." initiated December 2011, "Bilateral 1/4 rails for bed mobility" initiated 2011, "Encourage independence in mobility" initiated June 2012, and "Use sit to stand lifter for all transfers" initiated April 2014. * "...impaired thought processes r/t [related to] short term memory loss" revised May 2013 -	F 157	**MONITOR** The DNS or designee will audit all incidents, and change in condition weekly for appropriate notification for 4 weeks and then randomly for 4 weeks. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.	

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F 157	Continued From page 3 Interventions included: "Assist [resident's name]...to contact...brother...for support with decision making" initiated 2010. * "[Resident's name] attends activities of interest/choice...friends and family visits on a regular basis" revised April 2015 - Interventions included, "...[Resident's name] has family that he talks to on a daily basis on his phone... [Resident's name] has family that comes and visits and are a wear [sic] of his cares..." A Post Fall Investigation, dated 5/29/15, included the following documentation: * The resident fell off the bed "from sitting position face first onto floor" at 6:20 a.m.; * "Staff assistance being given at the time of the fall"; * "Verbal Fall Description...: rsdnt [resident] was sitting in the center of the bed, while the CNA turned her back to grab the sit to stand behind her she started turning around and said "[Resident's name]" as he was leaning and began to fall." * "Patient is own responsible party 1. Yes - no family/responsible party notification required" Note: Another response option, "2. Yes - in addition, notify family/responsible party" was blank. * The resident complained of pain at 5 on a 0-10 scale and there were nonverbal signs and symptoms of pain; * Regarding the questions, "What were you trying to do? What were you doing right before the fall? What was different this time when you fell?" The response was the same, "Rsdnt did not remember what happened before the fall." * Comments: "Rsdnt sent to [name of hospital]...had significant pain...brother of rsdnt notified [at 9:30 am]..."	F 157		

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F 157	Continued From page 4 * The CNA who witnessed the fall wrote, "I had resident I [sic] the center of the bed he was sitting up straight with feet on the ground. We were having our normal morning conversation, I turned by back to grab the sit to stand right behind me as I turned around I noticed resident bending, I said his name and he fell toward [sic?] onto the ground, I notified the nurse immediately." Hospital records documented the resident arrived in the emergency room at 6:54 a.m. and was triaged (process to determine medical priority) 1 minute later. The resident's family was not notified of his change of condition and emergency transport for emergency care for more than 3 hours after the incident. On 6/18/15 at 5:50 p.m., the Administrator was asked about the delay in notifying the resident's family. The Administrator stated, "All I can say is it was because of the bustle of getting him out of here." The facility did not provide any other information regarding the issue.	F 157		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this	F 164	F 164 Resident Specific IDT team reviewed resident #4 and did not find him to have any adverse effect related to his psychological well being. . Other Residents Observations were made on rounds for 5 consecutive days and no breaches of privacy or confidentiality were noted.	8/17/15

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F 164	Continued From page 5 does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure privacy was provided during the provision of care for 1 of 8 sample residents (#4). The failure created the potential for a negative effect on the resident's psychosocial well-being related to the need for privacy. Findings include: On 6/16/15 at 10:20 a.m., DDCO #1 and CNA #8 were observed as they assisted Resident #4 into the restroom. The staff were then observed to assist the resident to stand up from his wheelchair and then CNA #8 was observed pulling down the resident's pants as both staff left the door to the room and the restroom door wide open; neither staff member attempted to pull the	F 164	Facility Systems Staff was educated to but not limited to Patient's rights and the right to privacy during cares. Monitor Rounds will be made daily x 4 weeks to observe for any privacy issues and recorded on audit tool. Any occurrence will be immediately corrected and further education completed	

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F 164	Continued From page 6 available privacy curtain during the observation. At this time, the resident's roommate dozed on and off on his own bed and had a direct view of the resident in the restroom. When the surveyor asked about the resident's privacy, the DDCO nodded yes with her head then pulled the privacy curtain. On 6/19/15 at 10:10 a.m., the Administrator, DNS and DDCO #1 were informed of the privacy issue. The facility did not provide any other information regarding the issue.	F 164		
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 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. This REQUIREMENT is not met as evidenced	F 280		8/17/15

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F 280	Continued From page 7 by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to revise care plans for 2 of 12 sample residents (#s 3 & 5), both of whom had care plans that documented foley catheter care, but the catheters were no longer in use for either resident. This had the potential to result in harm if residents did not receive appropriate care due to lack of direction in care plans. Additionally, catheter care was not care planned or provided for Resident #4's indwelling catheter, which created the potential for urinary tract infection, and Resident #5 did not have a bladder assessment completed after a foley catheter was removed, which created the potential for harm if the resident experienced a loss of bladder function due to incomplete assessments. Findings included: 1. Resident #3 was admitted to the facility on 3/31/15 with multiple diagnoses including cellulitis. The resident's 4/7/15 admission MDS assessment documented the resident had an indwelling catheter. The resident's ADL care plan documented an intervention on 3/31/15 of, "[Resident Name] is totally dependent on staff for toilet use. Foley cath in place. Bed pan for BM." The resident's Physician's order documented an order on 6/7/15 to discontinue the foley catheter. The resident's June 2015 CNA care flow sheet documented the resident had a foley catheter from 6/1 to 6/7/15 and had been continent of	F 280	F280 Resident Specific Care plans, and physician orders were reviewed for residents number, 3, 4 and 5. appropriate updates completed on care plans, with appropriate interventions added to flow sheets Other Residents All resident's with orders for catheter u se and care were indentified. Care Plans, specific physician orders for those residents were developed, reviewed and implemented. Approp]riate care plan revisions have been completed. Education was provided for nursing staff on appropriate procedures for obtaining and noting physician orders, developing a comprehensive care plan and completing revisions to the care plan reflecting changes in orders and resident condition including the need for documentation of care provided. Facility Systems Daily review of any orders pertaining to insertion/removal of or catheter care will be reviewed by IDT during center morning meeting. A comprehensive care plan will be developed by IDY following a comprehensive assessment of the resident. All effective changes to care plan and monitor flow sheets will be made at that	

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F 280	Continued From page 8 urine from 6/8 to 6/17/15. On 6/16/15 at 8:15 AM, the resident was observed in bed in his room. Two clean and unused urinals were observed, one on the resident's bed and one on the nightstand. The resident said he wanted two urinals available to him in case he needed a spare. On 6/18/15 at 10:05 AM, the DNS and DDCO were interviewed. When asked what the resident used for urinary continence, the DNS said, "He uses urinals." When asked if the care plan directed staff to use urinals for the resident, the DDCO said, "It doesn't." 2a. Resident #5 was readmitted to the facility on 3/17/15 with multiple diagnoses including hip fracture and urinary retention. The resident's 3/24/15 admission MDS assessment documented the resident had an indwelling catheter and was totally dependent on staff for toileting. The resident's current care plan contained a Foley catheter care plan with a revision date of 6/7/15, and documented multiple interventions related to the catheter. The resident's ADL care plan, dated 6/7/15, documented, "Foley care q[every] shift and PRN." The resident's Physician's order documented an order on 6/9/15 to discontinue the foley catheter. On 6/15, 6/16, and 6/17/15 the resident was observed and the resident did not have a foley catheter. On 6/17/15 at 9:07 AM, the resident was	F 280	time. Education will be implemented for nursing staff concerning proper procedure for provider orders, care and monitoring of catheters and care plan revisions with the provider orders and resident change of condition. Monitor Weekly audit will be done and recorded of documentation for any residents with catheter orders to ensure that all orders are documented and done appropriately. Care Plans will be audited weekly for these residents to ensure proper revisions and interventions have been made and implemented Care plans and flow sheets will be reviewed quarterly with each MDS,Catheters, Care plans, documentation of catheter care and equipment, necessity of and infection control will be monitored in PI/QA meeting monthly by the IDT team for any issues with care, use and/or infection and treatment of such.	

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KINDRED TRANSITIONAL CARE & REHAB - LEWISTON	3316 8TH STREET LEWISTON, ID 83501

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F 280	Continued From page 9 observed in the bathroom with CNA #6 assisting the resident. After cares were completed, CNA #6 said the resident urinated and no longer had a catheter in place. She said the resident wore briefs and was occasionally continent. On 6/18/15 at 10:00 AM, the DNS was interviewed with DDCO #1 present regarding the resident's urinary care. When asked if he still used the foley catheter, the DNS said he did not. When asked why the catheter care plan was still on the care plan, she said, "The care plan should be updated." When asked if there was a urinary care plan to direct staff on the resident's urinary incontinent needs, she said, "No." On 6/19/15 at 10:10 AM, the Administrator, DNS and DDCO #1 were informed of the issues. No further information was provided by the facility. 2b. The resident's June 2015 Physician's Order documented an order for a foley catheter with an order date of 4/5/15. The resident's current care plan included catheter care, but did not document a urinary plan of care. The resident's June 2015 CNA care flow sheet documented the resident had a foley catheter from 6/1 to 6/8/15 and had been incontinent of urine for most shifts from 6/9 to 6/17/15. The resident's 6/9/15 Progress Notes documented the resident's catheter had come out on its own due to deflation of the balloon. The resident's Physician's order documented an order on 6/9/15 to discontinue the foley catheter.	F 280		

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	135021	A. BUILDING _____ B. WING _____	06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB - LEWISTON	3315 8TH STREET LEWISTON, ID 83501

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F 280	Continued From page 10 The resident's record did not contain a bladder assessment to determine bladder function or toileting needs. On 6/18/15 at 10:00 AM, the DNS was asked if a bladder assessment was completed after the catheter removal, she stated, "Negative." When asked if there was a urinary care plan to direct staff on the resident's urinary incontinent needs, she said, "No." 3. Resident #4 was admitted to the facility in 2012 and readmitted 3/12/15 with multiple diagnoses which included benign prostatic hyperplasia (BPH) and bladder retention. The clinical record contained documentation that an indwelling urinary catheter was in place when the resident was readmitted on 3/12/15 and that attempts to discontinue the catheter on 3/21/15 and 5/7/15 were unsuccessful due to retention and suprapubic pain. The resident's Physician Orders for April 2015 included, "Foley cath-change q [every] month 3/21/15." And, for June 2015, the orders included, "5/17/15 Foley cath - change q month & PRN [as needed] 16 F [French]10cc [10 cubic centimeter balloon]." A 6/3/15 "Comprehensive Physician's Order Sheet..." documented, "(1) With next routine catheter change, leave foley [sic] out and give voiding trial. If unable to void then replace [with] 16 Fr[ench] foley [sic]." The resident's care plan included the focus area "...Foley Catheter: d/t [due to]...retention ...BPH." It was initiated 3/5/15 and revised 6/7/15.	F 280		

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F 280	Continued From page 11 Interventions included, "Change catheter per policy / physician order" and "Urology follow up as needed and per physician order." The care plan did not include catheter care. The resident's TARs for May and June 2015 did not include catheter care. The ADL flow sheets for April, May and June 2015 did not include catheter care, and nursing progress notes, dated 3/12/15 through 6/16/15, did not contain any documentation about catheter care. There was no documented evidence that catheter care was provided when the indwelling urinary catheter was in place. On 6/16 and 6/17/15, the resident was observed with a urinary catheter in place. On 6/18/15 at 4:55 p.m., the DNS and DDCO #1 were asked if catheter care was care planned or if it was provided when the resident's urinary catheter was in place. The DNS reviewed the care plan and confirmed that catheter care was not included. The DNS said that catheter care would have been documented by the CNAs. The DNS reviewed the ADL flowsheets then stated, "I don't see anything about cath care, just peri care."	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		8/17/15

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F 309	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and policy review, it was determined the facility failed to provide the necessary care and services for 3 of 8 sample residents (#s 2, 4 and 7). Failure to recognize a lack of bowel movements for 9 days for Resident #2. Failure to notify a urologist of concerns about Resident #4's twice a day dosing of Flomax for benign prostatic hyperplasia (BPH or prostate gland enlargement) placed the resident at increased risk for pain or difficult urination. And, failure to obtain Resident #7's lab tests as ordered, created the potential for delay in necessary treatments. Findings included: 1. Resident #2 was admitted to the facility on 2/11/14, and re-admitted on 12/23/14, with multiple diagnoses which included osteomyelitis, spinal stenosis, pressure ulcer on the right heel contractures of multiple joints, peripheral neuropathy and muscle weakness. The 12/23/14 care plan documented the following: * Potential for constipation related to decreased mobility and medication side effects. The Facility Bowel Care Protocol, documented the following: * The CNA was responsible to document bowel movements each shift on the flow sheet. * The night nurse was responsible to review the CNA flow sheets. * No bowel movement in 48 hours, the nurse was to administer 30 CC of milk of magnesium, per	F 309	F309 Resident Specific Resident's 2,4,7 were reviewed for all areas indicated and resident number #4 has appointment with a different Urologist (was scheduled prior to survey) on 7/22/2015 to address Flomax dosage. Resident #7 has all ordered labs completed and resident #2 has had no bowel issues. Other Residents All resident's bowel documentation has been reviewed to reveal no further issues with any other residents. All lab orders have been reviewed and all orders are completed, all pharmacy recommendations have been reviewed by DNS and RPH and phone calls have been made for any pharmacy consultant recommendations that have not been evaluated and/or acted upon in order to reach resolution. Facility Systems Bowel protocol developed and approved by medical director and PI committee for use by all residents. This protocol will be included in admission orders for all residents for approval by the attending	

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F 309	Continued From page 13 physician order. * No bowel movement for 72 hours, the nurse was to administer 15 MG Dulcolax suppository, per physician order. * No bowel movement by the following morning, the nurse was to administer fleets enema, per physician order. * No bowel movement within 2 hours phone MD for additional orders. The resident's ADL flowsheet, dated 11/2014, documented the resident did not have a bowel movement for 11 days, from 11/01/14-11/11/14. The November 2014 MAR, documented the following: * No documented interventions for constipation for 9 days, from 11/01/14-11/09/14. * Bisacodyl 5 mg tablets, administered on 11/10/14 and 11/11/14, day 10 and 11 day of no bowel movement. Progress notes from 10/30/14-11/13/14 documented the following: * 11/03/14 at 3:15 PM - Resident requested to go to hospital for uncontrolled pain to right knee, heel, and stomach. The resident was treated in the ER, with IV fluids and antiemetic (medication to control nausea and vomiting) and discharged to the facility with an order for new pain medication. * 11/04/14 at 11:05 AM - Continued to complain of nausea, refused antiemetic. 12:56 PM - Complained of nausea, refused food despite encouragement and offers of alternative food, requested order for oral nausea medications from physician. * 11/05/14 at 2:43 PM - Refused pain medications during shift, resident believed pain medications	F 309	physician. A tickler file has been established for follow up and outcome of RPH recommendations that are reviewed by DNS and sent to physician for evaluation. All new orders for lab/x-ray are reviewed daily in morning meeting and added to calendar for timely completion by lab or x-ray. Education for nursing staff will include bowel protocol and proper implementation of same. Education for proper procedure for pharmacy consultant recommendation follow up and timely order and completion for all diagnostics including labs and x-rays will also be completed. Data to be sent to physician visits will be prepared by the supervising nurse and will include all pertinent data. Monitor All bowel sheets will be reviewed daily in morning meeting to monitor bowel movements and bowel protocol will be implemented as indicated. All lab and x-ray orders are reviewed in morning stand up meeting for scheduling and completion, this will continue indefinitely. Tickler file will be reviewed weekly by DNS or designee to track return and follow up of RPH recommendations, issues with follow up by physicians will be referred to the Medical Director through the PI committee. This will continue indefinitely. Data sent for physician visits will be reviewed every am in morning meeting x4 weeks for completeness. Weekly random audits will be completed after this for 4 more weeks.	

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F 309	Continued From page 14 were causing nausea. 10:19 PM - Refused antibiotics and food due to upset stomach, had difficulty taking medications. * 11/06/14 at 1:45 PM - Poor appetite and intake. * 11/07/14 at 9:02 PM - Complained of pain and discomfort from antibiotic therapy. * 11/09/14 at 1:38 PM - Poor appetite, refused to get out of bed, be turned or repositioned. * 11/10/14 at 11:54 AM - Declined being weighed because of pain, poor appetite, nausea at times and refused medications to help nausea. 1:30 PM - Decreased appetite, Bisacodyl 5 MG tablets given for constipation * 11/11/14 at 11:28 AM - Resident stated, "I just don't feel good." 10:07 PM Bisacodyl suppository and prune juice administered. * 11/12/14 at 12:25 AM - Refused to have temperature taken, no bowel movement yet. 6:34 AM - Refused all medications at 4:00 AM, and 5:00 AM. At 9:08 AM - Physician informed of resident ' s refusal of care, including turning, repositioning, poor appetite, limited intake, refusal to have weight done, no bowel movement for 10 days. 12:53 PM - Physician ordered transfer to local hospital, "large BM occurred as they were preparing her for transport, as this was one of the potential issues needing addressed." The facility ' s failure to follow its own bowel protocol resulted in a delay of treatment for the resident for constipation, which led to increased nausea and pain. On 6/19/15 at 8:15 AM, the DNS and RN #2 were informed of the findings. The DNS stated the resident should have received bowel care interventions within 48 hours of not experiencing a bowel movement.	F 309		

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F 309	Continued From page 15 On 6/19/15 at 11:30 AM, the Administrator was informed of the findings. No additional information was provided that resolved the findings. 2. Resident #4 was admitted to the facility in 2012 and readmitted 3/12/15 with multiple diagnoses which included benign prostatic hyperplasia (BPH) and bladder retention. The resident's Transfer Orders to Long Term/Skilled Facility and facility Admission Orders Record, both dated 3/12/15, included the order, "Tamsulosin HCL [brand name Flomax] 0.4 mg [milligram] capsule...give 1 capsule orally 2 times a day." No other orders for tamsulosin (Flomax) were found in the resident's clinical record. The resident's May and June 2015 MARs contained documentation that Flomax 0.4 mg was administered twice daily in the "AM" and "PM." A 4/15/15 Consultation Report by the pharmacist documented, "Comment: [Resident's name] receives tamsulosin (Flomax) 0.4 mg bid [2 times/day]...This formulation is manufactured for 24 hours dosing. Recommendation: Please consider discontinuing the tamsulosin 0.4 mg bid and initiating tamsulosin to 0.8 mg daily approximately 30 minutes after the same meal each day." The resident's physician declined the recommendation on 5/17/15 and documented, "I defer this to Urology." Note: The Nursing 2016 Drug Handbook by Wolters Kluwer included the following regarding Flomax: * Dosages for BPH - "Adults: 0.4 mg once daily,	F 309		

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F 309	Continued From page 16 given 30 minutes after same meal each day. If no response after 2 to 4 weeks, increase dosage to 0.8 mg P.O. [by mouth] once daily." * Patient Teaching - "Tell patient to take drug about 30 minutes after same meal each day. Health Status Notes in Progress Notes included the following: * 5/6/15 at 4:49 p.m. - "Fax sent to PCP [primary care provider] re[garding]: ...urology appt [appointment] for July 20th." * 6/3/15 at 6:46 p.m. - "Rsdnt [resident] received new orders from urologist, with the next routine catheter change , we are to leave foley [sic] out and try a voiding trial, if unable to void [urinate]...replace with a 16 fr [French] catheter...follow up with urologist in 6 to 8 weeks." The clinical record contained documentation that the resident was seen by a urologist on 6/3/15. However, there was no evidence the pharmacist's recommendation regarding Flomax was addressed with the urologist before, during or after that appointment. On 6/18/15 at 4:55 p.m., the DNS and DDCO #1 were asked about the resident's Flomax. The DNS said the facility had a "hard time" finding a urologist but they did get the resident in with a urologist in another town several miles away. The DNS said it was a "first visit." When asked if the pharmacist's recommendation was sent to the urologist, the DNS stated, "I don't know. I didn't send it." The Flomax dosing issue, identified by the pharmacist on 4/5/15, still was not addressed by the time of the survey, 2 and 1/2 months later. The facility did not provide any other information	F 309		

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F 309	Continued From page 17 regarding this issue. 3. Resident #7 was admitted to the facility on 5/26/15 with multiple diagnoses which included aftercare following surgical intervention of a right hip fracture, aspiration pneumonia, septic shock, hypothyroidism and restless leg syndrome. The resident's 5/26/15 Discharge Plan/Home Instructions from the referring hospital and the Admission Orders Record for the facility both included the following laboratory (lab) tests orders: CBC (complete blood count), BMP (basic metabolic panel), UA (urinalysis) and INR (International Normalized Ratio, used to monitor the effectiveness of warfarin (Coumadin) an anticoagulant medication) on 5/29/15. Review of the resident's clinical record revealed the aforementioned lab tests were not done until 6/1/15 which was 3 days later than ordered. On 6/18/15 at 1:50 pm, the DNS and DDCO #1 were asked about the resident's lab tests ordered for 5/29/15. The DNS reviewed the resident's paper chart and found the lab tests dated 6/1/15. The DNS stated, "I don't know why it wouldn't have been done on Friday (5/29/15)." And, the DDCO reviewed the resident's electronic chart and said she did not see any documentation in the nursing progress notes. The DNS then stated, "Friday is considered the weekend. Physicians don't have labs done on Friday unless it's stat (urgent)." The DNS confirmed, however, that the lab test ordered for Friday 5/29/15 were not stat orders. The facility did not provide any other information regarding the issue.	F 309		

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review and policy review, it was determined the facility failed to ensure a smoking assessment was conducted for 1 of 2 residents (#7) observed smoking cigarettes. The failure created the potential for burn injuries if the resident smoked while unsupervised. Findings include: Resident #7 was admitted to the facility on 5/26/15 with multiple diagnoses which included aftercare following surgical intervention of a right hip fracture, aspiration pneumonia and septic shock, and a history of hypothyroidism and restless leg syndrome. On 6/16/15 at 8:08 a.m., the resident was observed in a wheelchair (w/c) next to her bed. An over bed table was in front of the resident and an oxygen (O2) nasal cannula (NC) was on the over bed table. The NC was connected to an O2 concentrator. On 6/16/15 at 9:25 a.m., the resident was interviewed in her room with her son present. The resident was still in the w/c and the O2 NC was	F 323	F323 Identified Residents A smoking assessment has been completed for resident #7 and care plan updated to indicate current smoking status Other Residents All residents that smoke or who have indicated they may want to smoke has smoking assessments. All Care Plans have been updated to document resident's current smoking status. Facility Systems The facility will determine through record review and interview process a patients smoking history and current smoking status. A smoking assessment will be completed for any patient that currently smokes or who has smoked in the last 3 months. A care plan will be developed for current or potential for smoking and assessments will be done quarterly thereafter for any patient that is smoking and will be updated for any change of condition and care plans revised accordingly. Staff will be educated on the policy and procedure for completing smoking assessments and updating care plans	8/17/15

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F 323	Continued From page 19 on the bridge of her nose. A few minutes later, she put the NC into her nostrils. The resident said she did not like to wear the O2 NC all the time and stated, "I take it off sometimes and they [facility] don't like that." The resident also said she smoked cigarettes and that "sometimes" she would go outside and take "a puff or two on a cigarette." She added, "They don't like that either." When asked if she wore the O2 or if the portable O2 was on her w/c or if any O2 was nearby when she smoked, the resident stated, "No!" (Refer to F 328 for details about the O2.) On 6/17/15 at 9:21 a.m., the resident and the resident's son were observed in the designated smoking area. The resident was smoking a cigarette. On 6/18/15 at 9:20 a.m., the resident, the resident's son and 2 young adult male visitors were observed in the designated smoking area. The resident independently held, lit, and then puffed on the cigarette. The resident's clinical records contained a Progress Notes Health Status Note, dated 6/8/15 at 10:48 p.m., which documented, "...Rsdnt [resident] was upset because she stated that she wanted to go out and 'take some puffs' from a cigarette. Both CNA and this LN stated procedure about smoking evaluation by DNS. Rsdnt became upset and stated that she 'was an unsafe smoker.' She said that she falls asleep when smoking and needs another person to watch her or take her cigarette when she can't hold it anymore. Rsdnt was upset because one of the staff couldn't watch her and thought evaluation procedure was absurd." However, a smoking assessment was not found when the resident's	F 323	Monitoring Smoking assessments will be updated quarterly with the MDS process and care plans will be updated accordingly. IDT will review smoking assessment for any change of condition identified by staff in morning meeting x 8 weeks.	

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F 323	Continued From page 20 clinical records were further reviewed. On 6/18/15 at 1:50 p.m., the DNS and DDCO #1 were interviewed. They were informed of the aforementioned observations and asked to provide a smoking assessment. The DNS said she was "unaware" the resident had smoked while at the facility and that a smoking assessment had not been done. The DNS said the resident may have had cigarettes and a lighter in her purse. On 6/19/15 at 8:05 a.m., the DNS was asked to provide the facility's policy on smoking. Later that morning, the DNS provided a Smoking Policy, which documented that an assessment would be "performed upon admission, quarterly, and with a change of condition to determine whether a resident may smoke independently, supervised, or assisted with protective equipment." The facility did not provide any other information.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328	Identified Resident Resident #7 was assessed for oxygen needs, status, orders and equipment. Orders and care plan are updated to reflect current status and that is reflected on the aide's daily flow sheets and MARS and TARS as indicated.	8/17/15

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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 328	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, resident, family and staff interviews, and record review, it was determined the facility failed to ensure 1 of 1 sample residents (#7) who used oxygen (O2) had an order and a care plan for the O2. Without orders and a care plan, staff did not know what O2 liter flow rate or if continuous or PRN (as needed) O2 was needed, which created the potential for the resident to receive inadequate or inappropriate respiratory care. Findings included: Resident #7 was admitted to the facility on 5/26/15 with multiple diagnoses which included aftercare following surgical intervention of a right hip fracture, aspiration pneumonia, and septic shock. On 6/16/15 at 8:08 a.m., the resident was observed in a wheelchair (w/c) next to her bed. An over bed table was in front of the resident and an O2 nasal cannula (NC) was on the over bed table. The NC was connected to an O2 concentrator which was turned on. A portable O2 tank was also on the back of the resident's w/c. On 6/16/15 at 9:25 a.m., the resident was interviewed in her room with her son present. The resident was still in the w/c and the O2 NC was on the bridge of her nose. The resident said she had just blown her nose. A few minutes later, the resident put the NC into her nostrils. The NC was connected to an O2 concentrator that was set a 2.5 liters per minute (LPM). The portable O2 tank on the back of the resident's w/c was not turned on; however, the dial on the portable tank was set at 2 LPM. The resident's son said the setting on the portable O2 tank was "wrong" and that he	F 328	Other Residents All residents with current oxygen orders are reviewed for appropriateness, accuracy of treatment and equipment and care plan status. All orders reflect current oxygen needs and are addressed on the flow sheets, MARS/TARS and care plan appropriately. Facility Systems All new patients' orders are reviewed in daily stand up and will be reconciled to orders received from the transferring agency and reflected appropriately on the Care Plan, aide flow sheets, MARS/TARS. Staff education regarding oxygen orders, required equipment needs and maintenance and 02 settings will be completed Monitor All oxygen settings will be monitored q shift for 5 days following admission of any patient with oxygen orders x 4 weeks by LN Documentation of equipment care will be monitored daily by LN x 4 weeks and weekly for 4 weeks thereafter.	

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	135021	A. BUILDING _____ B. WING _____	06/19/2015

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F 328	Continued From page 22 was going ask the staff about it. The resident said she did not like to wear the O2 NC "all the time," and "I take it off sometimes and they [facility] don't like that." The resident also said she smoked cigarettes and that "sometimes" she would go outside and take "a puff or two on a cigarette." She stated, "They don't like that either." When asked if she wore the O2 or if the portable O2 was on her w/c or if any O2 was nearby when she smoked, the resident stated, "No!" (Refer to F 323 for details about the smoking.) On 6/16/15 at 10:35 a.m., the resident was not in her room, however her son was in the room. The son said he had not yet talked to staff about the O2 setting, but that he still planned to talk to them. The O2 concentrator was still on and it was set at 2.5 LPM. On 6/16/15 2:20 p.m., CNA #9 was observed as she assisted the resident into the restroom. The resident was not wearing/using the O2 NC before or while she used the restroom. While waiting for the resident, the CNA was asked about the O2. The CNA stated, "She's supposed to wear it all the time, but she refused a lot. We try to get her to use it but she goes out with family a lot and she takes it off." After the CNA assisted the resident out of the restroom, she offered the NC to the resident, however the resident refused the O2. Review of the resident's clinical records on 6/16 and 6/17/15 revealed the following: * "Septic shock...currently on 2 liters of oxygen and will be continued on same at skilled nursing home..." according to a 5/26/15 hospital Discharge Summary. * No orders for O2 in the transfer orders from the	F 328		

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F 328	Continued From page 23 hospital or in the facility's Admission Orders Record, both dated 5/26/15; and, no interim or clarification orders for O2. * The care plan did not address the resident's respiratory status or include anything about O2 use. * The June 2015 MAR documented, "Change O2 tubing every Monday noc [night]. Clean O2 concentrator filter q [every] wk [week] on Monday noc. Change O2 Humidifier every week on Monday noc. Apply water trap to oxygen tubing & change q wk on Monday noc." All directives were documented as completed only once, on 6/8/15, while the spaces to document on 6/15/15 were all blank. * Health Status Notes in Progress Notes, dated 5/27/15 and 5/28/15 noted O2 was in use, but did not include the O2 liter flow rate or if the O2 was continuous or PRN. On 6/18/15 at 1:50 p.m., the DNS and DDCO #1 were interviewed. They were asked to provide an order and a care plan for the resident's O2. The DNS reviewed the resident's clinical records then confirmed there were no orders and no care plan regarding the resident's O2 or respiratory status. The DNS said the resident came to the facility with O2 and that the resident would "desat [low O2 saturation level] when she would remove the NC." The DNS also confirmed that O2 use was not consistently documented. The DDCO added, "For a while we did not have a supervisor and that could have been part of the problem. We have a supervisor now." The facility did not provide any other information regarding the issue.	F 328		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		8/17/15

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F 329 SS=D	Continued From page 24 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 ensure residents' medications: *Were not duplicated; *Were adequately monitored; and, *Included an indication for use. These failures created the potential for harm due to receiving unecessary medications and the potential adverse consequences from duplicate	F 329	F329 Identified Resident Resident #8 has had ordered clarified with instructions and indications for administration and a sleep monitor is in place to assess resident's sleep pattern. Resident #7, orders have been clarified and now have diagnoses and indications for use. Other Residents All existing orders are reviewed for diagnosis and indication for use and contain all required components Facility Systems Nursing staff will be educated on the correct components of a physician order including indications for use and diagnosis Monitor All orders new orders are reviewed daily in standup for completeness and appropriateness including indications for use and diagnosis. All orders are reviewed by IDT team on a monthly basis for correct data entry and completeness including but not limited to indications for use and diagnosis, this is an ongoing daily and monthly process.	

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F 329	Continued From page 25 therapy. This was true for 2 of 12 (#s 7 & 8) sampled residents. Findings included: 1. Resident #8 was readmitted to the facility on 4/13/15 with multiple diagnoses which included Huntington's Chorea. The resident's May and June 2015 MAR documented orders dated 4/13/15 for PRN Temazepam and PRN Trazodone at bedtime for insomnia. The May 2015 MAR documented the resident received the Temazepam 22 of 31 days and the Trazodone 5 of 31 days. The resident received both medications on 5 of 31 days. The June 2015 MAR documented the resident received the Temazepam 2 of 18 days reviewed, and the Trazodone 1 of 18 days reviewed. The medical record did not include sleeping monitors to evaluate the medications' efficacy. The resident's care plan documented on 3/1/15 a focus of, "[Resident uses Hypnotic medication R/T [related to] Sleep disruption," and an intervention of, "Sleep monitor to monitor hours awake and hours slept." The facility's Pharmacy Consultation Report, dated 5/20/15, documented: "Comment: REPEATED RECOMMENDATION from 3/17/15...[Resident #8] has multiple PRN orders for medications with similar indications, which may result in two medications with similar undesirable adverse side effects being administered concurrently. Trazodone and temazepam for insomnia. Recommendation:	F 329		

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F 329	Continued From page 26 Please considered clarifying the administrative sequence for these orders to minimize the risk of adverse consequences from duplicative therapy...Ranges are not allowed with these orders, since the order could be interpreted differently by each caregiver." The report contained a space for the Physician to respond to the recommendation and to sign and date the form, but these areas were blank. On 6/17/15 at 4:55 PM, LN #7 was interviewed regarding the medications. The resident's June 2015 MAR was reviewed by LN #7, who was asked which PRN medication she would administer to the resident. LN #7 said she would ask the resident, start with the lower dosage medication or look at the MAR to see which medication had been given the most. On 6/18/15 at 10:10 AM, the DNS was interviewed with DDCO #1 present. When asked to explain why the resident received duplicate therapy for insomnia, DDCO #1 said, "I couldn't find any note in the chart." When asked what nurses would do during medication pass with the duplicate orders, the DNS said they would ask the resident and use nursing judgement, but "with an order like that we cannot refuse the med[ication]." When shown the MAR's lack of documention for hours of sleep and asked if nurses were to track hours of sleep, the DNS said, "I would agree with that." 2. Resident #7 was admitted to the facility on 5/26/15 with multiple diagnoses which included aftercare following surgical intervention of a right hip fracture, DVT (deep vein thrombosis) prophylaxis, hypoxic respiratory failure, septic	F 329		

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F 329	Continued From page 27 shock, left lower lobe aspiration pneumonia, hypothyroidism and restless leg syndrome. The resident's hospital transfer orders and facility Admission Orders Record, both dated 5/26/15, included 3 medications that did not have a diagnosis or the indication for use. The medications were: meloxicam 7.5 milligrams daily, liothyronine 5 micrograms daily and aspirin 81 mg daily. The Nursing 2016 Drug Handbook by Wolters Kluwer documented the indications for the aforementioned medications as follows: * meloxicam (brand name Mobic), an antirheumatic - "To relieve signs and symptoms of osteoarthritis or rheumatoid arthritis (RA)...[and] pauciarticular or polyarticular course juvenile RA." * liothyronine (brand names Cytomel and Triostat), a thyroid hormone replacement - "Congenital hypothyroidism[,] Myxedema [a condition resulting from advanced hypothyroidism, or deficiency of thyroxine[,] Myxedema coma, premyxedema coma[,] Simple (nontoxic) goiter[,] Thyroid hormone replacement [and] T3 suppression test to differentiate hyperthyroidism from euthyroidism (normal thyroid gland function). * aspirin (many brand names, such as Bayer, Ecotrin and St. Joseph to name a few), a non-steroidal anti-inflammatory drug (NSAID) - "Rheumatoid arthritis, osteoarthritis, or other polyarthritic or inflammatory condition[,] Juvenile rheumatoid arthritis[,] Mild pain or fever; spondyloarthropathies[,] Suspected acute MI [myocardial infarction or heart attack][,] To reduce risk of MI in patients with previous MI, unstable angina, and chronic stable angina pectoris[,] To reduce risk of recurrent transient ischemic	F 329		

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F 329	Continued From page 28 attacks and stroke or death in patients at risk[,] CABG [coronary artery bypass graft][,] Percutaneous transluminal coronary angioplasty[,] Carotid endarterectomy[,] Kawasaki disease [inflammation in the walls of arteries, including the coronary arteries, in children][and] Polycythemia vera [slow-growing type of blood cancer in which the bone marrow makes too many red blood cells." On 6/19/15 at 8:00 a.m., the DNS and DDCO #1 were asked what the indication for use or diagnosis was for the medications. The DNS and DDCO reviewed the hospital transfer orders and the facility admission orders, then they confirmed that a diagnosis or indication for use was not documented. The DDCO said the physician had recently signed the orders and returned them to the facility and the diagnoses may be on that copy. The DDCO said she would check the signed orders and get back with the surveyor. On 6/19/15 at 9:00 a.m., the DNS provided a 5/26/15 Discharge Summary which documented the diagnosis or indication for use for 9 of 12 medications. However, the Discharge Summary did not include the diagnosis or indication for use for the meloxicam, liothyronine or aspirin. The facility did not provide any other information regarding the issue.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		8/17/15

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F 332	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to maintain a medication error rate of less than 5%. This was true for 4 of 30 medications (13%) which affected 2 of 5 residents (#4, and random resident #15) observed during the medication pass. This failed practice created the potential for less than optimum benefit from prescribed medications that were not administered as ordered. 1. Resident #15 was admitted to the facility on 5/30/15 with multiple diagnoses, including Bipolar disorder. On 6/16/15 at 8:25 AM, RN #3 was observed as she administered 1/2 of a 300 MG ER Lithium Carbonate tablet. Review of the June 2015 physician recapitulation orders documented: * " Lithium ER 300 MG 1/2 tab in AM, 1 tab in PM, start medication as soon as possible. " - 6/5/15 * "Change lithium to 150 mg po am (instead of 1/2 of 300 mg)." - 6/9/15 Current Federal Drug Administration prescribing information for Lithium Carbonate documented: * Extended- Release tablets must be swallowed whole and never chewed or crushed * Toxic concentrations for Lithium occur at doses close to the therapeutic range. On 6/16/15 at 8:25 AM, RN #3 was observed as she administered 1/2 of a 300 MG ER Lithium	F 332	F 332 Identified Residents Resident #15, medication in question was changed to correct form and is now receiving complete tablets I n correct dosage as ordered. Resident #4 is receiving inhaler treatment per prescribed administration protocols. Other Residents All residents with inhaler orders were identified and nurses are checked off on proper inhaler administration protocols. Facility Systems Education completed regarding noting physician orders, rules and regulations surrounding cutting of any medication. Pharmacy informed of error and facility protocols about cutting medications. Education will be completed regarding correct procedure for administering inhaler medications. Nurses identified with drug pass issues will be educated on those errors incurred during survey and proper medication pass procedures all nurses will be reviewed at least annually for competencies of medication pass and more often if issues are identified. All nurses have now been satisfactorily observed for medication pass procedures.	

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F 332	Continued From page 30 Carbonate tablet, to Resident #4. On 6/17/15 at 1:20 PM, RN Nurse Manager #4 stated the Lithium medication should have been changed to 150 MG whole tablets on 6/9/15, however the 300 mg half was administered from 6/9/15 to 6/17/15. She stated the medication should not have been cut. On 6/19/15 at 11:30 AM, the Administrator was informed of the findings. No additional information was provided that resolved the findings. 2. Resident #4 was admitted to the facility on 10/2/12 with multiple diagnoses, including Type II diabetes, and pneumonia. The June 2015 physician recapitulation orders documented: * Ventolin HFA 90 mcg. inhaler, inhale 1 puff by mouth 3 times a day. * Pulmicort 180 mcg. flexhaler, inhale 2 puffs by mouth 2 times a day. * Levimer 100 units/ml vial, inject 7 units Sub-Q every morning. On 6/19/15 at 7:30 AM, RN #3 was observed to draw up 6 units of Levimer from 100 units/ml vial, and obtain the Ventolin HFA 90 mcg. inhaler, and Pulmicort 180 mcg flexhaler. At 7:50 AM, RN #3 entered Resident #4's room and asked the resident if he wanted some water before receiving his Ventolin HFA. Inhaler. When the resident completed one inhalation, RN # 3 handed the Pulmicort flexhaler and the resident completed the administration of both medications in less than 35 seconds. The RN did not instruct the resident to rinse his mouth to prevent oral	F 332	Monitoring All new nurses will be evaluated and verified on competencies surrounding the administration of all medications which will include inhaler medication and protocol on cutting medications. . Yearly competencies will be completed by all nurses employed at the center. Random audits will be done weekly on 2 randomly selected patients by DNS or designee regarding administration of inhaler medication. All new orders will be reviewed daily in standup for any indications of instructions for scoring the medication. This is an ongoing daily procedure.	

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F 332	Continued From page 31 candidiasis (yeast) and wait at least two minutes between inhalations. RN #3 then administered 6 units of Levimer insulin into the abdomen of the resident. On 6/16/15 at 10:40 AM, RN #3 stated she knew there was a wait time between inhalers, but could not recall the recommended amount of time, and acknowledged the resident should have been instructed to rinse his mouth after administration. RN #3 also stated she should have administered 7 units of insulin as ordered, rather than the 6 units the resident actually received. On 6/17/15, RN Nurse Manager #4 was informed of the findings. No other information was provided to resolve the concerns.	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, it was determined the facility failed to ensure a resident was free from significant medication error. This was true for 1 of 5 residents (#4) observed during medication pass. This deficient practice had the potential for harm if Resident #4 experienced one of the possible side effects of Lithium toxicity such as cardiac arrest, kidney failure, central nervous system impairment. Resident #4 was admitted to the facility on	F 333	F 333 Identified Residents See F 332 Other Residents See F 332 Facility Systems See F 332 Monitors See F 332	8/17/15

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F 333	Continued From page 32 5/30/15 with multiple diagnoses, including bipolar disorder. The June 2015 physician recapitulation orders documented: * Lithium ER 300 MG 1/2 tab in AM, 1 tab in PM, start medication as soon as possible. - 6/5/15 * "Change lithium to 150 mg po am (instead of 1/2 of 300 mg)." - 6/9/15 The current Federal Drug Administration prescribing information for Lithium Carbonate documented, " Extended- Release tablets must be swallowed whole and never chewed or crushed and toxic concentrations for Lithium occur at doses close to the therapeutic range. " On 6/16/15 at 8:25 AM, RN #3 was observed as she administered 1/2 of a 300 MG ER Lithium Carbonate tablet, to Resident #4. On 6/17/15 at 10:15 PM, RN #3 stated 1/2 a tablet (150 MG) of 300 MG Lithium ER was administered to Resident #4. On 6/17/15 at 1:20 PM, RN Nurse Manager #4 stated the Lithium medication should have been changed to 150 MG whole tablets on 6/9/15, however 1/2 of 300 MG ER tablets of Lithium were administered from 6/9/15 to 6/17/15. She stated the medication should not have been cut in the first place.	F 333		
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	F 431		8/17/15

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F 431	Continued From page 33 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit 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 and staff interview, the facility failed to ensure topical medications were securely stored and not accessible to residents. Unsecured medications in the 100 Hall Nursing Supervisor room created the potential for a negative affect if independently mobile,	F 431	F 431 Identified Residents Those residents identified as independently mobile and cognitively impaired are protected from accessing drugs and biological by a locked cart and locked door Other Residents Residents in the center are protected from accessing drugs and biological by locked cart behind locked doors. Systems Change Signage on door to remain locked. Education to staff on locking and storage procedures for treatment cart. Monitor Door and cart lockage will be checked q shift on rounds by DNS or designee x 4 weeks. Will then be checked daily on rounds by DNS or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135021	A. BUILDING _____ B. WING _____	06/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB - LEWISTON	3315 8TH STREET LEWISTON, ID 83501

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F 431	Continued From page 34 cognitively impaired residents ingested the medications or applied them incorrectly. Findings included: On 6/16/15 at 8:10 a.m., a staff member told the surveyor that the Nursing Supervisor room next to room 102 was a storage room. At 6/16/15 at 8:15 a.m., the Nursing Supervisor room, next to room 102, was found unlocked. The following medications were observed unsecured on a counter, on top of a treatment cart and in the unlocked drawers of the same treatment cart: * Counter: - One 400 gm jar Silver Sulfadiazine cream 1%; - One 6 fluid oz spray bottle of Wound Cleanser; and - One 5 oz tube of Clear Moisture Barrier with antifungal. * Top of treatment cart: - One 200 milliLiter (mL) bottle of Dakin's solution 1/4 strength; and - One 500 mL bottle of Dakin's solution 0.0125%. * Top drawer if treatment cart: - One 3 ounce (oz) bottle of antifungal powder; - One tube of Triamcinolone acetonide cream 0.1% with the warning "External use only"; - Four 100 gram (gm) tubes of Voltaren Gel (diclofenac sodium); - Two 4 oz tubes of Calazime skin protectant paste (one in a ziplock bag without a cap) with the warning "External use only"; - One 30 gm bottle of Nystop (Nystatin topical powder); - One 2 oz tube of Hemorrhoidal ointment; - One 60 grain (gr) tube of Nystatin and Triamcinolone Acetonide cream; - One 60 gr tube of Fluocinonide 0.05% with the warming "External use only";	F 431		

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F 431	Continued From page 35 - One 45 gm tube Clotrimazole and Betamethasone Dipropionate cream with the warning, "For topical use only. Not for ophtalmic (eye), oral, or intravaginal use" and - Two 85 gr tubes of Silver Sulfadiazine cream 1%. The contents of the 2nd and 3rd drawer in the treatment cart were similar to those in the top drawer. On 6/16/15 at 8:40 a.m., LN #4 entered the aforementioned Nursing Supervisor room while the surveyor was still in the room. The LN said she had been "alerted" the room was unlocked and she had come to lock it. The LN acknowledged that the medications on the counter, on top of the treatment cart and in the treatment cart drawers were not secured. The LN locked the door to the Nursing Supervisor room as she and the surveyor left the room. On 6/19/15 at 10:10 a.m., the Administrator, DNS and DDCO were informed of the unsecured medications issue. The facility did not provide any other information regarding the issue.	F 431		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MDS001370	A. BUILDING: _____ B. WING _____	06/19/2015

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KINDRED TRANSITIONAL CARE & REHAB - LE	3315 8TH STREET LEWISTON, ID 83501

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C 000	16.03.02 INITIAL COMMENTS The following deficiency was cited during the State licensure survey of your facility. The survey team included: Linda Kelly, RN, Team Coordinator Brad Perry, BSW, LSW and Becka Watkins, RN.	C 000		
C 422	02.120,05,p,vii Capacity Requirments for Toilets/Bath Areas vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not provide each resident floor or nursing unit with least one tub or shower for every twelve licensed beds. This resulted in the facility lacking the number of required tubs or showers and created the potential to effect all residents at the facility. The findings included: The facility was licensed for 96 beds. However, the facility had only 8 bathing areas, including the bathing areas in the therapy room. On 6/18/15, the Administrator confirmed there were only 8 bathing areas in the facility and she	C 422	C-422 We are requesting a waiver for his tag as we have a portable tub that enables residents to bathe in their room if they desire and gives them an alternative to shower, providing the resident with choices about their bathing type.	8/17/15

RECEIVED

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C 422	Continued From page 1 requested to continue the waiver for the bathing areas.	C 422		