



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

June 20, 2016

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

Provider #: 135019

Dear Mr. Bell:

On **June 10, 2016**, a survey was conducted at Kindred Nursing & Rehabilitation - Nampa by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency 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. 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.

Todd "Shane" Bell, Administrator
June 20, 2016
Page 2 of 4

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 **June 30, 2016**. Failure to submit an acceptable PoC by **June 30, 2016**, may result in the imposition of penalties by **July 30, 2016**.

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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **July 25, 2016 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **July 25, 2016**. A change in the seriousness of the deficiencies on **July 25, 2016**, may result in a change in the remedy.

Todd "Shane" Bell, Administrator
June 20, 2016
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **September 8, 2016** includes the following:

Denial of payment for new admissions effective **September 8, 2016**. [42 CFR §488.417(a)]

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 7, 2016**, 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 **September 8, 2016** 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>

Todd "Shane" Bell, Administrator
June 20, 2016
Page 4 of 4

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 **June 30, 2016**. If your request for informal dispute resolution is received after **June 30, 2016**, 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,

A handwritten signature in cursive script that reads "Debby Ransom".

Debby Ransom, RN, RHIT,
Chief, Bureau of Facility Standards

Enclosures

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

PRINTED: 11/28/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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>A Federal Recertification and Complaint survey was conducted at the facility from June 6, 2016 to June 9, 2016.</p> <p>The surveyors conducting the survey were:</p> <p>Presie C. Billington RN, Team Coordinator Nina Sanderson, LSW David Scott, RN Teresa Kobza, RD, LD Jenny Walker, RN</p> <p>Definitions include:</p> <p>AD - Activity Director AKA- Above the Knee Amputation AMA - Against Medical Advice A1C- Glycated Hemoglobin BG- Blood Glucose COPD - Chronic Obstructive Pulmonary Disease DNS- Director of Nursing Services DP - Discharge Planner Dx- Diagnosis Gm- Grams H&P - History and Physical ICC- Infection Control Committee LSW - Licensed Social Worker MARS- Medication Administration Records MD- Physician MDS- Minimum Data Set Mg- Milligram Mg/dl- Miligrams per Deciliter NN- Nurses Note NP - Nurse Practitioner PCP - Primary Care Provider PICC - Peripherally Inserted Central Catheter PN - Progress Notes</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

06/29/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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	Continued From page 1 PROM - Passive Range of Motion RNA - Restorative Nursing Assistant TARS- Treatment Administration Records TV - Television UTI - Urinary Tract Infection %- Percentage II- Two	F 000			
F 153 SS=C	483.10(b)(2) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interview, it was determined the facility failed to ensure residents were informed about and able to access their clinical records. This was true for two random residents (#16 and #17) and had the potential to affect all other residents in the facility. Findings include: The facility's Notice of Privacy Practices, dated 7/19/13 provided to all residents upon admission to the facility, documented residents had the right to inspect and copy their records, for which the facility would "charge a fee for the associated cost of labor, mailing, or other supplies." The	F 153	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Health & Rehabilitation <input type="checkbox"/> Nampa does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	7/20/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 153	<p>Continued From page 2</p> <p>notification did not specify a cost for the copying or that the cost would not exceed the "community standard."</p> <p>The 7/19/13 Notice of Privacy Practices also documented, "All requests made under this section must be made in writing" to the facility. The notice did not notify residents that such requests could also be verbally submitted.</p> <p>On 6/7/16 at 1:15 pm, 2 of 9 residents attending a group interview with surveyors stated they had each experienced difficulties accessing their clinical records. Random Resident #17 stated she received the "wrong" copies of her record and Random Resident #16 stated she was told she was not allowed to review her clinical record.</p> <p>On 6/8/16, the acting-Administrator stated the facility charged the same cost as the public library to copy clinical records for residents or their interested parties, and that copies were provided upon written or verbal request. He noted the facility required large record requests to be submitted in writing to ensure the complete and accurate scope of documentation was copied and provided.</p> <p>The acting-Administrator stated the facility's Notice of Privacy Practices did not inform residents or interested parties that copies would be furnished at "community standard" expense and that copies of records could be requested verbally rather than only in writing.</p>	F 153	<p>F 153</p> <p>Resident Specific The interdisciplinary (ID) team reviewed resident #16 and #17's request for records. Both residents were interviewed and did not at this time request any copies or reviews of their medical records. They were educated that if they ever want any of their medical records that they can ask the Medical Records department, Director of Nursing Services (DNS) or Executive Director (ED).</p> <p>Other Residents Resident rights regarding accessing medical records were discussed with resident council and with residents at the monthly resident meeting with DNS and ED. No other residents were identified as having requested medical records.</p> <p>Facility Systems The Staff Development Coordinator (SDC) and/or DNS have re-educated facility staff on policy and procedure for resident rights regarding medical records requests. Re-education was provided to include but not limited to, resident rights for requesting medical records may be verbally or in writing. If there is a volume of records, they will be provided at "reasonable cost based fees" per HIPAA and HITECH ACT guidelines. The system is revised to include an addendum to the admission agreement. It has been added</p>		

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

PRINTED: 11/28/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 153	Continued From page 3	F 153	to include requests for medical records which may be made verbally or in writing and will be provided at "reasonable cost based fees" per HIPAA and HITECH ACT guidelines. Monitor The ED and/or designee will review twice monthly during resident council and at ED/ DNS monthly meeting with residents. Starting the week of June 16, the review will be documented on the resident council minutes and ED DNS meeting minutes. Any concerns will be addressed immediately and discussed with the Performance Improvement (PI) committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Compliance July 20, 2016		
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	F 157		7/20/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA		STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 157	<p>Continued From page 4</p> <p>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).</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, policy review and staff interview, it was determined the facility failed to ensure physician of 1 of 13 (#4) sampled residents was notified of a low blood sugar. The failure to notify the MD of a hypoglycemic event had the potential of the resident to experience a life threatening complication. Findings include:</p> <p>The facility's Diabetes Mellitus Management policy and procedure, dated 10/9/12, stated the staff was to monitor residents for hypoglycemic (low blood sugar) episodes and if the results were less than 70 mg/dl to then notify the physician.</p> <p>Resident #4 was admitted to the facility on 3/1/16 with diagnoses which included Diabetes Type II</p>	F 157	<p>F157 Resident Specific The clinical management team reviewed resident #4 blood sugar monitoring records. The physician was notified and reviewed the current medications. An order was obtained for the blood glucose monitoring schedule. The family was notified as indicated.</p> <p>Other Residents The clinical management team reviewed other diabetic residents for blood glucose monitoring. Adjustments have been made as indicated.</p> <p>Facility Systems</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 157	Continued From page 5 with diabetic peripheral angiopathy (disease of the blood vessels) with gangrene, Diabetic Nephropathy (damage to kidney), Chronic Kidney Disease stage 4 without dialysis, and Unstageable Pressure Ulcer. Resident #4's care plan, dated 3/2/16, documented staff were to: * Provide diabetes medications as ordered by the MD and monitor and document for side effects and effectiveness * Check Resident #4's fasting blood glucose per MD orders * Follow the facility's hypoglycemia protocol if low BG's occurred * Monitor, document, and report signs and symptoms of hypoglycemia to the MD On 5/12/16 at 8:44 am, Resident #4's MARS/TARS documented a BG of 58 mg/dl. The notes did not document physician or family notification. The DNS stated the facility followed the Hypoglycemia policy and procedure for low BG levels. The notes did not include, and the facility could not provide, documentation regarding physician or family notification when Resident #4's BG was less than 70 mg/dl.	F 157	Licensed nurses are educated on hire for physician notification. Re-education was provided by the SDC and/or DNS to include but not limited to family and physician notification per the hypoglycemic protocol as indicated. The system is revised to review blood glucose monitors in clinical morning meeting to validate management by the policy. Monitor The DNS and/or designee will audit blood glucose testing for diabetic residents for blood glucose results lower than 70 mg/dl to validate appropriate family and physician notification is completed 5 days a week for 4 weeks, then 2 times weekly for 8 weeks. Starting the week of July 5th, 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 12 weeks, as it deems appropriate. Date of Compliance July 20, 2016		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest	F 250		7/20/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 250	<p>Continued From page 6</p> <p>practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review it was determined the facility failed to ensure the provision of medically related social services. This was true for 2 of 3 residents (#6 and #15) sampled for discharge planning. The deficient practice created the potential for harm when residents at risk of financial hardship from remaining in the facility, and/or homelessness upon discharge, were not provided with housing or financial referrals. Findings include:</p> <p>1. Resident #6 was admitted to the facility on 2/8/16 with diagnoses which included bacteremia related to a history of gangrene from frostbite and a right below the knee amputation. He was receiving daily antibiotics in the facility through a PICC line.</p> <p>On 2/15/16, Resident # 6's Admission MDS assessment documented he was cognitively intact, and could complete ADL's once set-up was provided. The responses to whether he had an expectation to return to the community, and whether he wanted to talk to someone about the possibility of returning to the community, were blank. The response to the question, "Is there an active discharge plan in place for the resident to return to the community?" was "yes." The response to the question, "Has a referral been made to the local contact agency (for community</p>	F 250	<p>F250</p> <p>Resident Specific The Licensed Social Worker (LSW) reviewed resident #6 discharge plan. Housing and financial referrals have been made.</p> <p>Resident #15 has discharged as noted in the CMS-2567.</p> <p>Other Residents The ID team reviewed other residents anticipating discharge for financial or housing referral needs. Referrals have been made as indicated.</p> <p>Facility Systems Resident care services and discharge planning staff are educated to the discharge planning process. Re-education was provided by the LSW to include but not limited to, referrals and/or options for housing and financial support upon discharge. The system is amended to include documentation of referral for difficult situations to the LSW and the Ombudsman.</p> <p>Monitor The LSW and/or designee will audit</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 250	<p>Continued From page 7</p> <p>assistance with discharge planning)?" was "no."</p> <p>On 5/10/16, Resident #6's quarterly MDS assessment documented he was cognitively intact, had no mood or behavioral concerns, and was independent with ADLs, transfers, and mobility.</p> <p>Resident #6's care plan did not contain documentation of a discharge plan or barriers to that plan. There was no documentation regarding identification of discharge goals or barriers to those goals between 2/8/16, when Resident #6 was admitted to the facility, and 5/27/16.</p> <p>On 5/27/16 at 4:01 pm, the DP made an entry in the PNs for Resident #6 which documented the DP had been meeting with him in an attempt to "set up a safe discharge." The DP documented Resident #6 was giving conflicting information regarding his discharge destination, and local infusion clinics were unwilling to accept a referral to provide services for him.</p> <p>On 5/27/16 at 6:34 pm, the DP made an entry in Resident #6's PNs which documented the MD had determined Resident #6 would require aftercare including an infusion center, home health, and an orthopedic physician in order to ensure a "safe discharge." The PN documented when Resident #6 was informed of this, he became upset due to his perception of how his disability payments would be impacted if he remained in the facility after 6/1/16, and threatened to leave AMA. The DP documented, "He then stated, 'there is no confusion about how you and I have been coexisting,' apparently implying that there had been a contentious</p>	F 250	<p>discharge plans for documentation of referrals as indicated twice weekly for 4 weeks, then weekly for 8 weeks. Starting the week of July 5th, 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 12 weeks, as it deems appropriate.</p> <p>Date of Compliance July 20, 2016</p>		

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

PRINTED: 11/28/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 250	<p>Continued From page 8</p> <p>relationship between [Resident #6] and [the DP]. [Resident #6] has a tendency to become surly with those who set boundaries with him. [Resident #6] reported that we were forcing him to leave and find medications on the street. [DP] gave him several options - none of which he was willing to try."</p> <p>On 5/28/16 at 1:30 am, Resident #6's PNs documented, "[Resident #6] remains upset over the discharge options. 'I need to leave so that I can get my disability they will not pay me while I am here. I cannot reapply for it either'...His family was in to visit this [evening] and he is calmer now."</p> <p>On 6/6/16 at 10:00 am, during the initial tour of the facility, Resident #6 told the surveyor the DP was "making life miserable" for him, in terms of discharge. He said he would experience financial difficulties with Social Security and Medicaid since he had not been able to discharge before 6/1/16. The resident stated he would like to talk further with the survey team about his concerns.</p> <p>On 6/6/16 at 1:30 pm, Resident #6 stated he initially injured his leg several years ago, but did not have health insurance so was not able to seek treatment timely. He stated the leg became necrotic, became infected, and had to be progressively amputated over time. He had become unable to work through this process, and the bank had foreclosed on his home. Resident #6 stated he anticipated because he had to stay in the facility "longer than 120 days," he would incur a several thousand dollar share of the cost. Resident #6 expressed concern over how this financial setback would impact his ability to</p>	F 250			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 250	<p>Continued From page 9</p> <p>support his minor daughter. He reported just prior to his hospitalization in February, he had been living in his van, and his wife and daughter living with other family members. Resident #6 stated he did not get along with the DP, but had to work with her because, "she is the only way I can get out of here. But she doesn't answer my questions, and I don't think she knows the answers." Resident #6 stated he could tell his behavior changed for the worse when he talked to the DP, "and I wish I could stop myself so she would be more willing to help me." Resident #6 stated he had not received a referral to talk with anyone else about his discharge, and was not aware such referrals could be made.</p> <p>On 6/8/16 at 3:15 pm, the DP stated, "I know he thinks I don't like him, but I do." The DP stated Resident #6 was going to be discharged the previous week, but the community-based infusion clinics would not accept him as a patient due to past non-compliance issues. The DP stated Resident #6's PCP in the community was no longer willing to follow him for pain control. The DP stated Resident #6 became upset when she informed him of this development, and when the resident threatened to leave AMA she "begged him to stay." The DP stated after Resident #6 became upset, the NP came up with a plan that would allow him to be discharged, but he was so upset he was not willing to discuss the details and decided to stay. The DP stated she was aware Resident #6's primary concern with remaining in the facility was his perception of the financial implications, but she did not know much about the true financial impact because she did not understand how "disability" worked. The DP stated she was not sure if any of Resident #6's</p>	F 250			

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

PRINTED: 11/28/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 250	<p>Continued From page 10</p> <p>income could be protected to allow for him to support his minor child. The DP stated she did not know if something like that was possible. The DP stated she had not made a referral to the facility's LSW as she did not think the LSW had greater knowledge of the issues. The DP stated she did not see a need for a referral for someone else to assist with social services for Resident #6 in light of his expressed discomfort with her.</p> <p>On 6/9/16, the Acting Administrator stated that because Resident #6 had such a history of non-compliance, the facility had done everything they could do to ensure a safe discharge, and it was likely Resident #6 had exaggerated the financial impact of remaining in the facility beyond 6/1/16.</p> <p>2. Resident # 15 was admitted to the facility on 11/30/15 with diagnoses which included UTI, COPD, and hypothyroidism.</p> <p>Resident #15's Admission MDS assessment documented she was cognitively intact; had minimal depression; hallucinations and delusions were present; and she had behavioral indicators and rejection of care which did not present a danger to herself or others. The assessment also documented Resident #15 required extensive assistance from one person for dressing and hygiene.</p> <p>Resident #15's Admission H&P, dated 11/26/15, documented, "The patient has been homeless for at least several days, previous to this she had been living in motels and perhaps homeless shelter. She apparently could no longer stay at the shelter, has been living in her car for the past</p>	F 250			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 250	<p>Continued From page 11 several days. She does have a studio apartment available in the next week."</p> <p>On 12/1/15 at 5:45 pm, Resident #15's PNs documented the DP met with her. Resident #15 reported someone had taken her rental agreement for the apartment she had lined up. She was noted to express feelings of paranoia and delusions during the interaction. The DP documented Resident #15's son, "is hopeful that [DP] can help to find a good discharge location..."</p> <p>On 12/3/15 at 10:43 am, Resident #15's PNs documented the DP had met with her, with Resident #15 upset and searching her room for a "piece of paper." The DP documented she spoke with Resident #15 about mental health concerns, which caused her to become "very defensive." The DP documented Resident #15 was planning to be discharged to a motel on 12/9/15. There was no documentation of the reason Resident #15's discharge location had changed, or that the MD was notified of her intent to leave the facility on 12/9/15. The next documentation in Resident #15's record regarding discharge planning was 12/21/15.</p> <p>On 12/21/15, the DP documented in Resident # 15's PNs that she had met with her and informed her of the end of her Medicare coverage for her stay in the facility. Resident #15 informed the DP that the apartment to which she was planning to move into upon discharge was not available. The DP documented Resident #15 accepted the notification of the end of her coverage, but hand-wrote an addendum stating she believed the DP and the facility were hiding other funding sources from her. The DP further documented</p>	F 250			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 250	<p>Continued From page 12</p> <p>Resident #15 declined to apply for Idaho Medicaid. Documentation that referrals for other resources, such as the Ombudsman, or information regarding subsidized housing, had been discussed or offered, was not found in Resident #15's record.</p> <p>On 12/22/15, Resident #15's Physician's Orders documented an order for Resident #15 to be discharged home with current medications, home health services, a walker, and a nebulizer machine.</p> <p>On 12/24/15 at 11:08 am, Resident #15's PNs documented, "Resident was discharged today at [11:00 am]...Resident was escorted to the company van..."</p> <p>On 12/28/15, Resident #15's Interdisciplinary Discharge Summary documented her discharge potential was "poor;" and that she had been discharged to her car, refused DME, and home health could not be arranged.</p> <p>On 6/8/16 at 3:40 pm, the DP stated at the time of admission, Resident #15 had informed her that she had placed a deposit on an apartment, which should be ready before the end of December, 2015. The DP stated at some point she had become aware that the arrangements for the apartment had "fallen through." The DP stated she had not pursued the issue further because Resident #15 had seemed intent on that particular apartment at the time of her admission. The DP stated that Resident #15 had limited financial resources, but she did not ask, and did not know, if Resident #15 qualified for or had applied for subsidized housing. The DP stated</p>	F 250			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 250	Continued From page 13 she had not made a "formal" referral to the facility's LSW, but that they always talked informally.	F 250			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, policy review and staff interview, it was determined the facility failed to ensure a) monitoring of BG levels followed the physician orders; b) the physician was notified when blood glucose levels were less than 70 mg/dl; and c) the facility's Hypoglycemia policy was implemented. This was true for 1 of 1 sampled resident (#4) reviewed for diabetes management. This failed practice created the potential for Resident #4 to experience complications related to unmanaged hypoglycemia. Findings included: The Lantus insulin product information, dated 7/15, stated hypoglycemia may be difficult to recognize in the elderly; frequent glucose monitoring and dose adjustments may be necessary for people with renal impairment; and people and caregivers must be educated to recognize and manage hypoglycemia (low blood sugar)... In people at higher risk for hypoglycemia	F 309	F309 Resident Specific The clinical management team reviewed resident #4 blood glucose monitoring process. The physician was notified and reviewed current medication and an order was obtained for blood glucose monitoring schedule. Other Residents The clinical management team reviewed other diabetic residents for blood glucose monitoring needs. Adjustments have been made and orders obtained as indicated. Facility Systems Licensed nurses are educated on hire for hypoglycemic management. Re-education was provided by the SDC	7/20/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 309	<p>Continued From page 14</p> <p>and people who have reduced symptomatic awareness of hypoglycemia, increased frequency of blood glucose monitoring is recommended.</p> <p>Facility's Diabetes Mellitus Management policy and procedure, dated 10/9/12, stated the staff was to monitor residents for hypoglycemic episodes and if the results were less than 70 mg/dl notify the physician. If the blood glucose was less than 70 mg/dl, the Hypoglycemia policy and procedure, dated 10/9/12, was implemented. The Hypoglycemia policy and procedure stated staff were to give the resident 15 gm of a fast acting carbohydrate, wait 15 minutes and then recheck the resident's BG. Staff was to repeat the steps until the BG level was above 70 mg/dl, and offer a snack if the next meal is longer than one hour away. These policies were not followed for Resident #4.</p> <p>Resident #4 was admitted to the facility on 3/1/16 with diagnoses which included Diabetes Type II with diabetic peripheral angiopathy with gangrene, Diabetic Nephropathy, Chronic Kidney Disease stage 4 without dialysis, and Unstageable Pressure Ulcer.</p> <p>Resident #4's 5/2/16 Quarterly MDS assessment documented he had no cognitive or decision making impairments.</p> <p>Resident #4's care plan, dated 3/2/16, documented staff were to:</p> <p>* Provide diabetes medications as ordered by the MD and monitor and document for side effects and effectiveness</p>	F 309	<p>and/or DNS to include but not limited to physician notification per the hypoglycemic protocol as indicated and the blood glucose monitoring schedule. The system is revised to review in clinical morning meeting residents with insulin order changes for appropriate blood glucose monitoring schedules and to validate blood sugar management by the policy.</p> <p>Monitor The DNS and/or designee will audit current and new diabetic residents ensuring blood glucose monitoring is in place and appropriate physician notification is completed for blood glucose results lower than 70 mg/dl. The audits will be 5 days a week for 4 weeks, then 2 times weekly for 8 weeks. Starting the week of July 5th, 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 12 weeks, as it deems appropriate.</p> <p>Date of Compliance July 20, 2016</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 309	<p>Continued From page 15</p> <ul style="list-style-type: none"> * Check Resident #4's fasting blood glucose per MD orders * Follow the facility's hypoglycemia protocol if low BG's occurred * Monitor, document, and report signs and symptoms of hypoglycemia to the MD <p>Resident #4's May 2016 physician recapitulation orders documented he received Lantus 35 units in the morning for diabetes beginning 4/6/16.</p> <p>On 5/12/16 at 8:44 am, Resident #4's MARS/TARS documented a BG of 58 mg/dl. The notes did not document interventions implemented or physician notification. The next documented BG was at 3:01 pm.</p> <p>On 5/18/16 at 3:31 pm, a NN documented to please review Resident #4's diabetes medication and BG's. The NN further stated the goal was to stabilize Resident #4's BG without the use of sliding scale insulin.</p> <p>On 5/19/16 the MD ordered the Sliding Scale Insulin to be discontinued and an A1C lab test was ordered. The order did not include information regarding checking Resident #4's BG levels.</p> <p>On 5/19/16, Resident #4's laboratory results documented an A1C of 6.9%.</p> <p>Resident #4's May 2016 MARS/TARS showed the staff checked Resident #4's BG's four times a day, before every meal and at bedtime. The BG checks were completed by staff through 5/19/16</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 309	Continued From page 16 at 4:30 pm, at which time they stopped, except for two random checks in June on the 1st and 9th. On 6/8/16 at 2:47 pm, the DNS stated the BG checks were discontinued when the sliding scale insulin was discontinued because the BG checks were tied into the order. She stated the facility followed the MD's orders for BG checks and currently they had no order for Resident #4. She stated the MD ordered an A1C level and that was when the MD determined the frequency of the BG checks. The DNS stated when someone was on Lantus only, BG checks were completed per MD orders. She stated a clarification to the order should have been done to check if the BG checks were to be discontinued as well. The DNS stated the facility followed the Hypoglycemia policy and procedure with low BG levels. The notes did not document, and the facility could not provide documentation regarding interventions, physician notification, and recheck Resident #4's BG when Resident #4's BG was less than 70 mg/dl.	F 309			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315		7/20/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 315	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure residents ability to safely self-catheterize was assessed. This was true for 1 of 2 residents sampled (#2) for urinary catheters. This failed practice created the potential for more than minimal harm should Resident #2 fail to self-catheterize in a safe and hygienic manner. Findings included:</p> <p>Resident #2 was re-admitted to the facility on 5/11/16 with diagnoses that included paraplegia, neurogenic bladder, recurrent UTI's, and pressure ulcers.</p> <p>The admission MDS assessment, dated 5/18/16, documented Resident #2 was cognitively intact, had no upper extremity limitations, and was independent with self-catheterization.</p> <p>Resident #2's care plan for June 2016, initiated 3/4/16, documented:</p> <p>*Focus - "[Resident #2] has a neurogenic bladder and self cathes every four hours, history of UTI's."</p> <p>*Goal - "[Resident #2] will not have problems with self cathing through review date. [Resident #2] will not have complications r/t neurogenic bladder through review date."</p> <p>*Interventions - "Ensure [Resident #2] has supplied [sic] he needs and maintains proper hand hygiene during self cares. Monitor/record/report to MD for s/sx UTI."</p>	F 315	<p>F315</p> <p>Resident Specific The clinical management team assessed resident #2 and determined him to be safe to perform self catheterization.</p> <p>Other Residents The clinical management team reviewed other residents for self catheterization. None were identified.</p> <p>Facility Systems Education was provided by DNS and/or SDC to licensed nurses including but not limited to, assessment of resident's ability for self catheterization in a safe and hygienic manner. The assessment will be documented, added to clinical record, and depicted in the plan of care. The system is amended to review in clinical morning meeting new admissions and/or those residents with order changes for self catheterization to validate assessment has been documented.</p> <p>Monitor The DNS and/or designee will audit newly admitted residents and those with order changes who self catheterize to ensure clinical assessment is complete, documented and added to plan of care for 5 times weekly for 4 weeks, then twice weekly for 8 weeks. Starting the week of July 5th, the review will be documented</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 315	Continued From page 18 Resident #2's clinical record did not include documentation of education, safety assessment, or performance evaluation related to his ability to safely and effectively self-catheterize. On 6/8/16 at 11:00 am, the DNS was asked to provide a self-catheterizing safety assessment and/or education documentation for Resident #2. At 11:30 am, the DNS highlighted a nurse's note written 5/13/16: "He is able to self cath[sic] staff just needs to empty the urinal after he is done."	F 315	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 12 weeks, as it deems appropriate. Date of Compliance July 20, 2016		
F 323 SS=E	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 and staff interview, it was determined the facility failed to ensure harmful chemicals were securely stored and inaccessible to residents. This was true for 4 of 4 sampled residents (#5, #9, #10, #13) and all other independently mobile, cognitively impaired residents. Failure to safely store harmful chemicals created the potential for serious eye damage. Findings include: On 6/6/16 at 2:30 pm, three mop buckets filled with orange fluid were observed unattended in	F 323	F 323 Resident Specific None Other Residents Administration immediately removed all mop buckets containing chemicals, and body wash/shampoo bottles when first alerted during survey. Rounds validate that no hazardous chemicals are available to residents.	7/20/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 19</p> <p>the soiled linen closets on the 100 and 300 hallways. The storage room closet on the 500 hallway was observed unattended with six shampoo/body wash bottles unsecured and accessible to cognitively impaired mobile residents. The label read, "Avoid contact with eyes."</p> <p>Residents #5, #9, #10, and #13, were identified as independently mobile and cognitively impaired.</p> <p>On 6/7/16 at 1:30 pm, surveyors observed, with the Maintenance Manager in attendance on the 100 hallway, a mop bucket filled with orange fluid in the soiled linen closet that was left unsecured. He said it should not have been there and directed surveyors to talk with the Housekeeper Manager about the policy. At 4:00 pm, a mop bucket filled with orange fluid on the 200 hallway soiled linen room was observed with the Housekeeper Manager. When asked what kind of fluid was in the mop bucket, she said the mop buckets in all the soiled linen closets for each hallway were filled with Stride Citrus cleaner. The label read, "Causes serious eye damage." The Housekeeper Manager said the mop buckets and the shampoo/body wash should have been in a secured location.</p> <p>On 6/7/16 at 4:45 pm, the Housekeeper Manager said the mop buckets and shampoo bottles were moved to a secured location.</p>	F 323	<p>Facility Systems Staff is educated on hire regarding chemical storage. The SDC has re-educated staff for storing chemicals in the facility, to include but not limited those dispersed in mop water and shampoo. The system is amended to include administration rounds validating mop bucket is locked in the closet and shampoo is stored properly.</p> <p>Monitor The SDC and/or designee will audit facility for proper chemical storage 5 times weekly for 4 weeks, then twice weekly for 8 weeks. Starting the week of July 5th, the review will be documented on the rounds 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 12 weeks, as it deems appropriate.</p> <p>Date of Compliance July 20, 2016</p>		
F 328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following</p>	F 328		7/20/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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	<p>Continued From page 20</p> <p>special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to assess a resident's ability to safely and independently provide adequate care for a colostomy. This was true for 1 of 1 (#2) resident sampled for colostomy care. This failed practice created the potential for more than minimal harm should Resident #2 fail to safely care for his colostomy independently. Findings included:</p> <p>Resident #2 was re-admitted to the facility on 5/11/16 with diagnoses that included paraplegia, neurogenic bowel with diverting colostomy, and pressure ulcers.</p> <p>The admission MDS assessment, dated 5/18/16, documented Resident #2 was cognitively intact, had no upper extremity limitations, and was independent with colostomy care.</p> <p>Resident #2's care plan for June 2016, initiated: 3/4/16, documented:</p> <p>*Focus - "Alteration in bowel elimination related to need for: diverting colostomy d/t recurrent</p>	F 328	<p>F328</p> <p>Resident Specific The clinical management team assessed resident #2 and determined him to be safe to perform his own colostomy care.</p> <p>Other Residents The clinical management team reviewed other residents for self colostomy care. None were identified.</p> <p>Facility Systems Education was provided by DNS and/or SDC to licensed nurses including but not limited to, assessment of resident's ability to safely and independently provide adequate care for their own colostomy. The assessment will be documented, added to the clinical record, and depicted in the plan of care. The system is amended to review in clinical morning meeting new admissions and/or those residents with order changes for self colostomy care to validate assessment</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 decubitus ulcers." *Goal - "[Resident #2] will have no signs of excoriation at stoma site through next review date." *Interventions - "Ensure appropriate supplies for ostomy care available. Self maintains." Resident #2's clinical record did not include documentation of education, safety assessment, or performance evaluation related to his ability to independently care for his own colostomy. On 6/8/16 at 11:00 am, the DNS was asked to provide self colostomy care safety assessment and/or education documentation for Resident #2. At 11:30 am, the DNS highlighted a nurse's note written 5/13/16: "Colostomy is patent. He is able to change his appliances (I)."	F 328	has been documented. Monitor The DNS and/or designee will audit newly admitted residents and those with order changes who provide self colostomy care to validate clinical assessment is complete, documented and added to plan of care for 5 times weekly for 4 weeks, then twice weekly for 8 weeks. Starting the week of July 5th, 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 12 weeks, as it deems appropriate. Date of Compliance July 20, 2016		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug	F 329		7/20/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 22</p> <p>therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure that prior to the use of an antidepressant medication, a resident's specific target behaviors were monitored to demonstrate adequate indications for its use. This was true for 1 of 13 (#4) sampled residents. The failed practice created the potential for harm if the resident experienced adverse outcomes due to the use of an unnecessary medication. Findings include:</p> <p>The manufacturer's recommendations for the anti-depressant, Remeron, state the medication is indicated for the treatment of major depressive disorder.</p> <p>Resident #4 was admitted to the facility on 3/1/16, with diagnoses which included Diabetes Type II with complications, AKA, Pressure Ulcer Unstageable, Obstructive Sleep Apnea, Heart Failure, and Chronic Kidney Disease stage 4 without dialysis.</p> <p>Resident #4's May 2016 physician recapitulation</p>	F 329	<p>F329</p> <p>Resident Specific The ID team reviewed resident #4 for appropriate behavior monitoring and use of antidepressant. Monitoring was initiated.</p> <p>Other Residents The ID team reviewed other residents with antidepressants for behavior monitoring. Adjustments have been made as indicated.</p> <p>Facility Systems Licensed nursing staff is educated to unnecessary drugs and medication management upon hire. Re-education was provided by the SDC and/or DNS to include but not limited to, behavioral monitoring prior to implementation of antidepressant. The system is amended to include review in clinical meeting of behaviors and a new order to validate</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 23 orders documented he received:</p> <p>* Remeron 30 mg at bedtime for depression with poor appetite beginning 4/21/16.</p> <p>Resident #4's discontinued orders from the March and April 2016 MARS documented he received:</p> <p>*Remeron 15 mg at bedtime as an appetite stimulant beginning 3/22/16 and discontinued 4/5/16.</p> <p>* Remeron 30 mg at bedtime as an appetite stimulant beginning 4/5/16 and discontinued 4/14/16.</p> <p>* Remeron 30 mg at bedtime as an appetite stimulant and for depression beginning 4/14/16 and discontinued 4/21/16.</p> <p>Resident #4's 5/2/16 Quarterly MDS assessment documented he had no behaviors, no cognitive or decision making impairments, and minimal signs of depression. Resident #4's Initial MDS assessment, dated 3/8/16, documented the same findings.</p> <p>Resident #4's care plan, dated 4/18/16, documented staff were to record if Resident #4 had adverse side effects of the anti-depressant and staff were to monitor and record mood symptoms. The findings were to be found on the MARS/TARS beginning 3/22/16.</p> <p>Resident #4's March 2016 MARS/TARS did not specify the targeted behaviors the staff was to monitor. Data was collected 3/22/16 at 7:00 pm</p>	F 329	<p>documentation occurs prior to change or addition of a medication.</p> <p>Monitor The medical records clerk and/or designee will audit behavior monitors for residents with antidepressants twice weekly for 4 weeks, then weekly for 8 weeks. Starting the week of July 5th, 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 12 weeks, as it deems appropriate.</p> <p>Date of Compliance July 20, 2016</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 24 to 3/23/16 at 9:41 am. There were no behaviors monitored.</p> <p>Resident #4's MARS/TARS anti-depressant side effects documented staff was to monitor for:</p> <ul style="list-style-type: none"> * sedation *drowsiness *dry mouth *blurred vision *urinary retention *tachycardia *muscle tremor *agitation *headache *skin rash *photosensitivity *weight gain *none <p>Resident #4's anti-depressant side effects on the March 2016 MARS/TARS documented "none".</p> <p>Resident #4's April 2016 MARS/TARS target behaviors, specified the staff was to monitor agitation and angry outbursts from 4/14/16 at 6:00 pm to 4/15/16 at 2:41 pm. Resident #4's behavior monitoring documented no behaviors. Resident #4's target behavior monitoring was changed on 4/18/16. As of that date staff were to monitor for irritability every shift. Resident #4's behavior monitoring documented no behaviors. Resident #4's April 2016 anti-depressant side effects documented "none". Monitoring was not completed in 8 instances.</p> <p>Resident #4's May 2016 MARS/TARS target behavior monitored for was irritability beginning</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	Continued From page 25 on 4/18/16 every shift with no stop date. Resident #4's behavior monitoring documented 1 episode of irritability for May. Resident #4's May 2016 anti-depressant side effects documented none or monitoring was not completed in 4 instances. Resident #4 supplemental Behavior Monitoring flow-sheet, included monitoring for irritability beginning 4/20/16. It documented 2 episodes of irritability out of 123 instances monitored. On 6/8/16 at 2:47 pm, the DNS stated the Remeron was ordered as an appetite stimulant in March and stated the facility asked for an order clarification for the medications use which they received 4/17/16 by getting a psychiatrist evaluation. The psychiatrist diagnosed Resident #4 with depression on 4/17/16. The notes did not include, and the facility could not provide, documentation that Resident #4 was diagnosed with depression prior to the initiation of the Remeron in March. The notes did not identify or document targeted behaviors prior to the initiation of the medication on 3/22/16.	F 329			
F 441 SS=E	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	F 441		7/20/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 441	<p>Continued From page 26 in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their 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 and staff interview, it was determined the facility failed to ensure residents engaged in hand hygiene when helping in the dining room. This deficient practice had the potential to impact 1 of 13 sample residents (#8) who dined in the assisted dining room, and any other resident who dined in the assisted dining room. The lack of hygiene created the potential for the spread of infection amongst the residents.</p>	F 441	<p>F441</p> <p>Resident Specific The ID team reviewed and educated resident #16 regarding proper hand hygiene when assisting in the dining room. Resident continues to assist with dining room by distributing the daily chronicle by completing hand hygiene</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 441	<p>Continued From page 27</p> <p>Findings included:</p> <p>On 6/7/16 at 10:30 am, Resident #16 was observed placing napkins at the place settings on the tables in the assisted dining room. Resident #16 was moving about in her wheelchair, using her feet to push an over bed table in front of her. A stack of cloth napkins and a box of paper napkins were on the table. Resident #16 was propelling her wheelchair with her hands. She was wearing a black bicycling glove on each hand. As she grasped the rim of the wheelchair rim to move, her thumbs and the palms of her hands between her thumbs and her wrists rubbed against the tread of the wheel itself, which had direct contact with the floor. After setting the napkins on six of the tables in the dining room, the box of paper napkins was empty. Resident #16 propelled her wheelchair to a white cabinet in the corner of the room, opened the cabinet, reached in with the same gloves she had been using to propel herself, and took a handful of napkins out of the box. She tucked the napkins in the space in her wheelchair seat between her thighs and the wheelchair arm. The napkins were in direct contact with her clothing, the wheelchair arm, and the wheelchair cushion. Resident #16 then began to place those napkins on the table tops. Resident #16 did not perform hand hygiene throughout the process.</p> <p>Resident #8 dined in the assisted dining room, creating the potential for the resident to contract an infection due to cross-contamination.</p> <p>On 6/9/16, the DNS and SDC were informed of the observation, and agreed the practice observed would not be considered sanitary.</p>	F 441	<p>then propelling herself by her feet to keep hands sanitary.</p> <p>Other Residents The ID team reviewed and educated other residents who are currently assisting in dining room regarding infection control when assisting in the facility. Adjustments have been made as indicated.</p> <p>Facility Systems Residents were educated at resident council meeting as well as monthly ED/ DNS resident meeting to include but not limited to, infection control procedures when assisting in the dining room or other areas within facility. Activities and nursing staff was educated by SDC to include but not limited to, infection control when residents assist in the facility and the monitoring of residents when they assist in the facility. The system is amended for administration rounds to include dining room set-up.</p> <p>Monitor The SDC and/or designee will audit residents assisting in dining room for infection control procedures 5 times weekly for 4 weeks, then twice weekly for 8 weeks. Starting the week of July 5th, the review will be documented on the rounds PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the</p>		

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

PRINTED: 11/28/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 441	Continued From page 28	F 441	monitoring after 12 weeks, as it deems appropriate.		
F 518 SS=F	<p>483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS</p> <p>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure staff were adequately prepared to respond to power outages. This was true for 1 of 3 (CNA #5) staff interviewed for emergency preparedness. This failed practice created the potential for more than minimal harm should a power outage occur that threatened the delivery of resident care. Findings include:</p> <p>On 6/8/16 at 3:00 pm, CNA #5 stated the facility's generator would turn on in 4 seconds in the event of a power outage and all the outlets in the rooms would work again. When asked about the red emergency outlets, CNA #5 was unaware when a power outage occurs only the red emergency outlets worked off the generator. CNA #5 did not know there were red emergency outlets in the hallways.</p> <p>CNA #5 stated she started employment about 3</p>	F 518	<p>Date of Compliance July 20, 2016</p> <p>F518</p> <p>Resident Specific N/A</p> <p>Other Residents N/A</p> <p>Facility Systems The SDC and/or designee educate new staff during general orientation to emergency preparedness. The SDC has re-educated staff to include but not limited to, power outages. The system has been amended to include the maintenance supervisor identifying red outlets and emergency bins during general orientation facility tour.</p> <p>Monitor The maintenance supervisor and/or</p>	7/20/16	

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

PRINTED: 11/28/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 518	Continued From page 29 months prior to the survey and received new employee orientation about the policy and procedures for emergency preparedness. CNA #5 stated she had not participated in an unannounced staff drill to test the efficiency, knowledge, or response of institutional personnel in the event of an emergency.	F 518	designee will audit staff response to power outage emergency preparedness 3 times monthly for 3 month. Starting the week of July 5th, the review will be documented on the interview 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 3 months, as it deems appropriate. Date of Compliance July 20, 2016		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001550	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - N	STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>An Annual Recertification and Complaint survey was conducted from June 6, 2016 to June 9, 2016.</p> <p>The surveyors conducting the survey were: Presie C. Billington RN, Team Coordinator Nina Sanderson LSW David Scott RN Teresa Kobza RD, LD Jenny Walker RN</p> <p>Definitions include: ICC - Infection Control Committee</p>	C 000		
C 666	<p>02.150,02,c Quarterly Committee Meetings</p> <p>c. Meet as a group no less often than quarterly with documented minutes of meetings maintained showing members present, business addressed and signed and dated by the chairperson. This Rule is not met as evidenced by: Based on staff interview and review of Infection Control Committee records, it was determined the facility failed to ensure a representative from each department attended the Infection Control Meetings at least quarterly. The lack of participation of all departments created the potential for negative outcomes for residents, visitors, and staff in the facility. Findings included: On 6/9/16 at 1:54 pm, the facility's Infection Control Program was reviewed with the Infection Control Nurse. The Infection Control Nurse provided the sign-in sheets from the monthly ICC meetings. Upon review of the sign-in sheets, it was determined the following departments were</p>	C 666	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation - Nampa does not admit that the deficiencies listed on the State Form exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p>	7/20/16

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 06/29/16
--	-------	------------------------------

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001550	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - N	STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

C 666	<p>Continued From page 1 not represented:</p> <ul style="list-style-type: none"> * Administrator and Medical Director for December 2015 meeting * Medical Director for January 2016 meeting * Medical Director, Maintenance and Pharmacy for February 2016 meeting * Administrator, Medical Director and Housekeeping for March 2016 meeting * Administrator, Medical Director, Maintenance, Nutrition Services Director, and Housekeeping for April 2016 meeting <p>On 6/9/16 at 2:35 pm, the Infection Control Nurse acknowledged the lack of participation in the meetings.</p>	C 666	<p>C666</p> <p>Resident Specific N/A</p> <p>Other Residents N/A</p> <p>Facility Systems SDC and or designee will validate that participants are at monthly infection control meetings and sign attendance roster to show that they were present at the meeting. Audits will validate compliance at least quarterly.</p> <p>Monitor The ED and/or designee will audit monthly infection control meeting minutes to ensure all parties are present and roster is signed by all participants. Starting June 22nd, 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 12 weeks, as it deems appropriate.</p> <p>Date of Compliance July 20, 2016</p>	
-------	---	-------	---	--



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P. O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

August 19, 2016

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

Provider #: 135019

Dear Mr. Bell:

On **June 10, 2016**, an unannounced on-site complaint survey was conducted at Kindred Nursing & Rehabilitation-- Nampa. This complaint was investigated during the facility's Recertification and State Licensure survey between June 6, 2016 and June 9, 2016.

The survey team made observations of provision of care and quality of life throughout the four day survey. Medication administration was observed over several days, several shifts, and with several nurses. Four individual resident interviews were conducted, as well as a resident group interview. The Ombudsman was interviewed. The facility's Acting Administrator, Director of Nursing, Staff Development Nurse, multiple Charge Nurses, and Certified Nursing Assistants were interviewed. The facility's grievance log was reviewed, and the Licensed Social Worker was interviewed. The records of thirteen current residents and two former residents, including the identified resident, were reviewed. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007214

Allegation #1:

The Reporting Party stated an identified resident did not receive medications as ordered by the physician, as the medications could not be found when they were due to be given.

Findings:

The medications identified by the Reporting Party were not ordered for the resident upon admission to the facility. The medications were ordered several days later, after the resident had been seen by the Nurse Practitioner. After the medications were ordered, the facility documented the medications were administered, except for two occasions when the resident declined them, which was the resident's choice. The resident later discussed the use of the medications with the Nurse Practitioner, and the order was changed to decrease the frequency of one of the medications. There were no other documented instances where the resident did not receive medications as ordered.

Conclusion:

Unsubstantiated. Lack of sufficient evidence.

Allegation #2:

The Reporting Party stated the facility had secured her wallet on the medication cart, which contained some expired credit cards. The Reporting Party stated the expired credit cards were missing.

Findings:

The identified resident signed an inventory sheet upon admission, which included a wallet. The wallet contents were not listed. At the time the resident discharged from the facility, s/he expressed concern keys were missing from the wallet, but no other contents were identified as missing. The nurse's progress notes in the identified resident's record documented the resident found the keys. The resident signed the inventory sheet again at the time of discharge, verifying all s/he had taken all belongings.

Individual residents, and those attending the resident group were asked about missing items in the facility. Residents interviewed stated they were able to report missing items to the facility, which were then either found and returned, or replaced. The residents interviewed reported no concerns with missing valuables.

The facility's grievance log contained evidence of missing items being found and returned, or replaced.

Conclusion:

Unsubstantiated. Lack of sufficient evidence.

Allegation #3:

The Reporting Party stated an identified resident was taking several medications at home, which were not being given in the facility. The Reporting Party stated the facility offered no explanation for this discrepancy. The Reporting Party stated the identified resident was also receiving duplicate blood pressure medications, causing a drop in blood pressure.

The identified resident had been in the hospital just prior to his/her admission to the facility. The hospital records documented the resident had a number of chronic health conditions, but was not taking any medications at home. While in the hospital, treatment was initiated for these chronic conditions. The resident's Physician's Orders for his/her admission to the facility included instructions for the treatments to be monitored and evaluated for effectiveness. The facility documented these treatments were carried out, the monitoring was completed as the resident allowed, and adjustments made to the treatment accordingly. The identified resident did decline to have blood drawn for evaluation of a thyroid treatment on one occasion.

Findings:

The identified resident was seen by either the Physician or the Physician's Assistant on six occasions over a period of twenty-five days. During each visit, the providers documented concerns from the identified resident regarding medications, treatments, and monitoring. The progress notes from each of these visits documented a review of the resident's vital signs, including blood pressure, with no documented concerns with low blood pressures.

The resident's admission orders to the facility included two blood pressure medications and a diuretic. The facility was monitoring the resident's edema and blood pressure. The resident intermittently declined one of those medications when offered. A Physician's progress noted from December 14, 2015 documented the resident stated she was taking too many medications. The Physician discontinued one of the blood pressure medications and the diuretic. The facility continued to monitor the resident's blood pressure and edema, with slight changes noted after the medications were discontinued. The Physician's Assistant reviewed these changes with the resident on December 17, 2015. At the resident's request, these changes were addressed with non-medication interventions. The resident discharged from the facility on December 24, 2015.

No discrepancies or errors with medication administration were noted during medication pass observations.

Conclusion:

Unsubstantiated. Lack of sufficient evidence.

Todd "Shane" Bell, Administrator
August 19, 2016
Page 4 of 4

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

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The "D" is stylized with a vertical line through it, and "Scott" is written in a cursive-like font.

David Scott, RN, Supervisor
Long Term Care

NS/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

August 19, 2016

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

Provider #: 135019

Dear Mr. Bell:

On **June 10, 2016**, an unannounced on-site complaint survey was conducted at Kindred Nursing & Rehabilitation - Nampa. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007230

The complaint was investigated in conjunction with the facility's on-site Federal Recertification and State Licensure survey conducted from June 6, 2016 to June 9, 2016. There were no residents in the facility at the time of the complaint investigation survey receiving IV therapies.

Allegation #1: The Reporting Party stated the identified resident did not receive IV (intravenous) antibiotic therapy twice daily as ordered by the physician because the facility did not have an electric pump to deliver the antibiotics. The Reporting Party stated the physician-ordered antibiotics were not initiated until two days after they were ordered to begin.

Findings #1: The identified resident's clinical record documented IV antibiotic therapy was ordered the day of admission and was administered once daily for seven days as physician ordered until the resident discharged from the facility.

The facility's Director of Nursing and District Director of Clinical Operations stated IV pumps and back-up pumps were in the facility and available during the resident's stay.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The Reporting Party stated the identified resident's Peripherally Inserted Central Catheter (PICC) line dressing was not changed.

Findings #2: The identified resident's physician orders included direction to staff to change the PICC line dressing site weekly and once daily as needed. The PICC line dressing site was scheduled for replacement the day the resident discharged from the facility. Clinical records indicate the dressing change was not performed prior to discharge and that this was acceptable to the resident.

Surveyors observed the dressing of the only resident with a PICC line in the facility at the time of the investigation. No issues of concern were identified.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The Reporting Party stated the identified resident and family member who requested copies of the resident's clinical record were not provided with the requested documents.

Findings #3: The family member identified by the Reporting Party was not listed on the identified resident's clinical record as a person authorized to receive or be informed of Private Health Information regarding the resident.

The facility's Health Information Management Director stated all requests for records, either by residents or their responsible parties, are documented in a records-request log as well as on a separate form, which is then placed in the applicable resident's clinical record. The identified resident's record did not contain a record-request form and the Health Information Management Director stated the facility's record-request log did not contain documentation that either the resident or family member had made such a request.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: The Reporting Party stated the identified resident's wound-vac care was not provided in a manner consistent with professional standards of care. The Reporting Party stated that upon discharge from the facility a surgeon said the resident's foot may require amputation due to the poor quality of care provided at the facility.

Findings #4: The identified resident's physician orders contained thirteen active orders directing staff in their cares of the wound, as well as the operation and maintenance of the wound vac machine. The resident's clinical record contained documentation that each of these physician orders related to wound care as well as wound vac operation and maintenance were completed per physician order.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Todd "Shane" Bell, Administrator
August 19, 2016
Page 3 of 3

Allegation #5: The Reporting Party stated the identified resident was not provided analgesic medications per physician order and the facility refused to obtain an alternative medication to the physician's ordered analgesic, which "upset" the resident's stomach.

Findings #5: The identified resident's physician orders contained two active orders for analgesic pain relief. The resident's clinical record contained documentation that pain was assessed regularly and analgesics were provided when warranted and consistent with physician orders.

The identified resident's clinical record also contained documentation related to attempts by individuals not employed by the facility and with no known medical background to give the resident non-approved analgesic medications. These efforts were thwarted by the facility in accordance with federal and state regulations and those individuals were provided with information regarding the provision of "outside" medication administration to residents within the facility.

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

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

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt