



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](mailto:fsb@dhw.idaho.gov)

July 8, 2016

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

Provider #: 135093

Dear Mr. Farnes:

On **June 23, 2016**, a survey was conducted at Kindred Nursing & Rehabilitation - Aspen Park by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

David Farnes, Administrator  
July 8, 2016  
Page 2

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 18, 2016**. Failure to submit an acceptable PoC by **July 18, 2016**, may result in the imposition of penalties by **August 5, 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 28, 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 **September 21, 2016**. A change in the seriousness of the deficiencies on **August 7, 2016**, may

David Farnes, Administrator  
July 8, 2016  
Page 3

result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 21, 2016** includes the following:

Denial of payment for new admissions effective **September 21, 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 20, 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 21, 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:

David Farnes, Administrator  
July 8, 2016  
Page 4

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

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

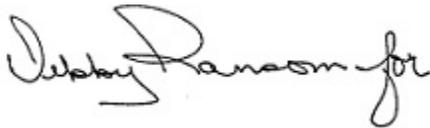
- BFS Letters (06/30/11)

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

This request must be received by **July 18, 2016**. If your request for informal dispute resolution is received after **July 18, 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,



Nina Sanderson, LSW, Supervisor  
Long Term Care

ns/  
Enclosures

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

PRINTED: 08/02/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - ASPEN PARK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>
--	--

(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><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the recertification and complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were: Presie C. Billington, RN - Team Coordinator David Scott, RN Jenny Walker, RN</p> <p>The survey team entered the facility on 6/20/16 and exited on 6/23/16.</p> <p>Acronyms used in this report include: AD - Activity Director BIMS - Brief Interview for Mental Status BWAT - Bates Jensen Wound Assessment Tool CM - Centimeter C/O - Complained of DON - Director of Nursing DR - Doctor DTI - Deep Tissue Injury D/T - due to IDT - Interdisciplinary Team LN - License Nurse MDS - Minimum Data Set assessment MG - Milligrams NS - Normal Saline PHQ-9 - Patient Health Questionnaire PN - Progress Notes PO - By Mouth PU - Pressure Ulcer PRN - As Needed QHS - At bedtime RN - Registered Nurse R/T - related to SDTI - Suspected Deep Tissue Injury TID - Three times a day</p>	F 000		
-------	--	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>07/18/2016</b>
---	-------	--------------------------------

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:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 TV - Television TX - Treatment W/C - Wheel chair WSC - Weekly Skin Check X - times	F 000			
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT  The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.  This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, it was determined the facility failed to ensure residents' rooms were maintained in a homelike and visually pleasing manner. This was true for 1 of 48 resident rooms (Room 316) and directly impacted 2 of 2 random residents (#14 and #15). This resulted in a 6 month delay in room maintenance and created the potential for residents to become dissatisfied with their living arrangements. Findings include:  On 6/21/16 at 7:55 am, a hole in the wall behind Random Resident #15's tilting recliner was observed in Room 316. The hole measured approximately 2.5-feet in length and varied in width, measuring approximately 2-inches at its widest point. Frayed wallpaper lined its edge and chunks of drywall were observed hanging from various points along its length.  Random Resident #14, who shared the room	F 252	F 252 D " The damaged wall in Room 316 was temporarily patched 6/21/16. The wall will be repaired in standard acceptable fashion before completion date below. " An audit of all other resident rooms was conducted by the maintenance department to identify any other walls with similar holes that needed repaired. Repairs will be completed as indicated. " The electronic software system Tels will be used to send work orders to the maintenance department identifying future issues with resident rooms. The ED provided education to Maintenance Department staff as to the importance of completing repairs timely. SDC or designee will educate other department staff in use of Tels to report damage in the rooms to Tels maintenance automated work order system.	7/28/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 252	Continued From page 2 with Random Resident #15, said at the time of the observation that the facility informed him the hole would be repaired "two-to-three months ago."  On 6/22/16 at 12:30 pm, the facility's Maintenance Director, when shown the hole in the wall, stated, "I knew it was there and we'll get to it when I get time." The Maintenance Director stated he was aware the wall was in need of repair for "about six months."  On 6/23/16 at 9:20 am, a board painted a different color from the surrounding wallpaper and attached to the wall with four screws was observed covering the hole in Room 316. When asked whether the repair was satisfactory to him, Random Resident #14 stated, "It's not the way I would have done it at my house."	F 252	" The ED or designee will use a PI audit tool to review 5 rooms each week x 4 weeks then 5 rooms bi-weekly for additional 8 weeks. The PI committee will review audit results and take action as necessary and may adjust the frequency of monitoring after 12 weeks as it deems appropriate.		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to ensure a resident who entered the facility without	F 314	F 314 G " Patient #3's pressure ulcers to the left and right heels will continue to be	7/28/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 314	<p>Continued From page 3</p> <p>a pressure ulcer, remained free from pressure ulcers. This was true for 1 of 7 (#3) residents sampled for pressure ulcers. Resident #3 was harmed when he developed a Suspected Deep Tissue Injury (SDTI) while in the facility which later became a Stage IV pressure ulcer. Findings include:</p> <p>Resident #3 was admitted to the facility with multiple diagnoses including, pneumonia and weakness.</p> <p>Resident #3's 4/22/16 Admission MDS assessment documented the following regarding his status:</p> <ul style="list-style-type: none"> <li>* Severely impaired cognition with a BIMS of 4</li> <li>* Required extensive assistance of one person for bed mobility, transfers, dressing, and personal hygiene</li> <li>* Totally dependent on staff for bathing</li> <li>* Required limited assistance for eating</li> <li>* Functional limitation in ROM to upper/lower extremities, and lower extremity impairment on both sides</li> <li>* At risk of developing a pressure ulcer</li> <li>* Did not have one or more unhealed pressure ulcer(s) at Stage 1 or higher</li> <li>* Had no other ulcers, wounds, or skin problems</li> <li>* His skin and ulcer treatment was, "pressure reducing device for bed and chair."</li> <li>* He was not on a turning or repositioning program.</li> </ul> <p>Resident #3's care plan documented:</p> <ul style="list-style-type: none"> <li>* Resident #3 was at risk for impaired skin integrity related to fragile skin, painful overgrown</li> </ul>	F 314	<p>managed by the Gritman wound clinic. Treatments are completed by facility staff per MD order.</p> <p>" A base line audit of interventions for other residents with a Braden Scale At Risk, Moderate or High risk score for pressure ulcers were evaluated. Adjustments to treatment plan will be made as needed.</p> <p>" The clinical management team will review residents on admit and quarterly thereafter based on the Braden Scale score. The results will be reviewed by the clinical management team and the interventions will be evaluated and adjustments made as needed. The clinical management team will review the communication report from Point Click Care in the clinical meeting. Resident□s identified with a change in mobility, cognition, pain, behaviors or new diagnosis of vascular disease, not limited to only these factors, will be reviewed for appropriate pressure ulcer interventions. SDC or designee will educate nursing staff as regards reporting to clinical management team any changes in mobility, cognition, pain, behaviors, not limited to only these factors.</p> <p>" DNS or clinical management team designee will use a PI audit tool to review 5 residents per week x4 weeks then, 3 residents per week x 2 weeks then 2 resident□s bi weekly for six weeks. The PI committee will review audit results and take action as necessary and may adjust the frequency of monitoring after 12 weeks as it deems appropriate.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 314	<p>Continued From page 4 toenails, initiated on 4/15/16. This plan was revised on 6/7/16 to reflect the DTI to his right and left heels.</p> <p>* Referral to podiatrist, initiated on 4/29/16.</p> <p>* Pressure reducing mattress and w/c cushion to protect his skin, was initiated on 4/18/16. This was revised on 6/1/16 to include heel lift boots to both feet at all times while he was in bed and in his w/c to protect his skin. Staff were to check often throughout shift to ensure the boots were in place and fitting properly.</p> <p>* His skin was to be kept clean and dry and lotion used on dry skin, initiated on 4/15/16.</p> <p>Resident #3's care plan did not document the need to float his heels or assist him with turning or repositioning.</p> <p>Resident #3's 4/15/16, Patient Nursing Evaluation documented:</p> <p>* He had no pressure ulcers. * He did have a non-pressure ulcer present. * Comments included, "Found bruising, scab and abrasion to bilateral extremities during assessment. Skin is pink, warm and very dry. Heel firm, ingrown toenails to L great toe."</p> <p>Resident #3's PN, IDT notes, Physician Order Request, and Wound Clinic Notes, documented the following:</p> <p>* 4/29/16 PN at 1:02 pm - Resident #3 was referred to a podiatrist for overgrown toenails.</p>	F 314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 314	<p>Continued From page 5</p> <p>* 5/2/16 PN at 4:57 pm - Resident #3 went out for his medical appointment and was prescribed Indocin 50 mg PO TID x 7 days then, 1 PO PRN for feet pain.</p> <p>* 5/3/16 - Podiatrist notes documented, "All of the patient's toenails are excessively elongated. Patient has pain with palpation of the toenails, one through 5 bilaterally. All of the patient's toenails are yellow in color, they exhibit crumbly subungual debris, and are misshapen." Resident #3's toenails were debrided. Instructions provided by the Podiatrist were, "Check feet daily, wear good shoes, replace shoes regularly." The Podiatrist diagnosed Resident #3 to have venous insufficiency and onychomycosis (fungal infection of the nail). The Podiatrist recommended elevation of Resident #3's feet and compression stockings.</p> <p>Resident #3's clinical record did not include documentation that the Podiatrist's instructions and recommendations to check Resident #3's feet daily, to elevate his feet, and apply compression stockings, were implemented. Following the 5/3/16 Podiatry assessment, Resident #3's care plan was not updated to include the use of heel protectors related to his diagnosis of peripheral vascular disease.</p> <p>* 5/25/16 - A Physician Order request at 12:00 noon stated, "Still complaining of foot pain, appears to be neuropathy related. Consider adding a med[ication] for this? Having difficulty working [with] therapies d/t reluctant to put feet on the floor." The physician ordered Gabapentin 300 mg PO QHS. Resident #3's record did not include documentation that the condition of his</p>	F 314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 314	<p>Continued From page 6 feet were assessed at this time.</p> <p>* 6/1/16 PN at 1:28 pm, stated, "...rated pain at 8/10. Meds per order...Working with therapy this am. Therapy looked at his heels after complained of pain. 2 areas noted on both heels. Reported to wound team, waiting for treatment recommendation, heels floated on pillows."</p> <p>* 6/1/16, PN at 3:58 pm - The wound nurse assessed Resident #3's feet and documented the following, "Left heel - Pressure, measuring 1 cm x 1.3 cm x 0 cm, stage, Suspected Deep Tissue Injury. Right Heel - Pressure, measuring 3 cm x 6 cm x 0.1 cm. Stage, SDTI. Dark grey colored skin along edge of heel with approx. 3 cm x 2 cm x 0 cm area on the medial aspect of wound that appears to be old calloused area with white/grayish yellow non viable tissue peeling away. Unable to visualize base of wound r/t non viable tissue in wound on medial aspect and intact discolored skin on rest of wound which is boggy upon palpation (SDTI). Right ankle outer - Pressure, measuring 2 cm x 2 cm x 0 cm. Stage, SDTI. Heel lift boots placed and care planned for use in bed and w/c to protect skin.</p> <p>* 6/2/16, PN at 4:30 pm - Resident #3 was seen by his physician and the LN on duty informed the physician via phone about the DTIs that were found on 6/1/16. Resident #3's physician was "very pleased to hear the heel lift boots were initiated and skin prep to wounds Q shift TID were ordered."</p> <p>* 6/7/16, PN - The Wound Nurse assessed Resident #3's wound and documented the following, "Left heel - Pressure measuring 1.2 cm</p>	F 314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 314	<p>Continued From page 7</p> <p>x 1.6 cm x 0 cm. Stage, SDTI. No change to appearance. Remains an intact DTI. Recommend no tx change at this time. Right heel - Pressure measuring 3.2 cm x 6.8 cm x 0.2 cm. Stage, SDTI. Pain when cleaned with NS. R heel and malleolus areas have merged to current DTI. Purple in color. DTI has open area in center (0.2 cm x 0.2 cm) with small amount bloody drainage present. Wearing heel lift boots. Recommend tx be changed to honey hydrogel covered with foam dressing.</p> <p>* 6/7/16 - Physician Order Request stated, "1. DTI to R heel appears to be deteriorating and has merged with malleolus area. Ok for wound clinic consult? In the meantime, ok for honey hydrogel and foam dressing, change daily and PRN? 2. Ok for multivitamins with minerals one tablet PO daily to promote wound healing?" Resident #3's physician said yes to all requests.</p> <p>* 6/9/16, PN at 10:39 am - The IDT met to review skin areas on Resident #3's heels and documented that the Wound team noted the areas to be DTIs. The PN documented that Resident #3 did not wear shoes due to toenail pain and currently wore slippers socks. The PN documented Resident #3 was to wear heel lift boots at all times in bed and in his wheelchair. It noted the MD gave orders, as well as, approved the request for Resident #3 to go to the wound clinic.</p> <p>* 6/15/16 - A Wound Clinic note at 12:30 pm stated, "...first noted on 6/1/16. He has a rapid decline in the level of functioning in the month of April...has become very dependent due to poor mobility and now very painful ulcer on the right</p>	F 314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 314	<p>Continued From page 8 greater than the left foot." Wound measurement and treatment included:</p> <ul style="list-style-type: none"> <li>- Right calcaneus wound, open, measuring 4 cm x 6 cm x 0.1 cm, limited to skin breakdown, with medium amount of serous drainage. Treatment provided and new orders included, "Debridement of the right wound. Clean wound with clean cleanser - DiDakSol, Iodosorb, Aquacel (plain), Mepilex (foam dressing), secure with Medipore.</li> <li>- Left Calcaneus wound, open, measuring 0 cm x 0 cm x 0 cm, limited to skin breakdown." Treatment was provided and new orders included, "Bordered foam Iodosorb, Mepilex, secure with Medipore.</li> <li>- Continue the off-loading boots on the feet at all times.</li> <li>- Minocycline 100 mg one tablet oral by mouth two times a day for infected ulcer starting 6/15/16.</li> <li>- Resident #3's right heel wound was assessed at the Wound Clinic as Stage 4 and the left heel wound was assessed as unstageable.</li> </ul> <p>* 6/21/16, PN at 7:18 pm - IDT notes documented, "Skin issue to bilat[eral] heel DTI and right lateral ankle DTI, it appears that cause of source of DTI's is unknown at this time but potentially related to not wearing shoes and having hallucinations, increased behaviors, delusions that resulted in refusing cares at times in his room as well as the DR, he has foot pedals in his w/c and when agitated may have resulted</p>	F 314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 314	<p>Continued From page 9</p> <p>in kicking feet on w/c pedals. On admission resident was identified for potential skin at risk and a pressure reducing mattress and w/c was in place as well as heel lift boots bilaterally. Resident also went to podiatrist for a painful ingrown toenail."</p> <p>Resident #3's Weekly Skin checks documented the following:</p> <ul style="list-style-type: none"> <li>* 4/24/16, "From looking [at] resident skin is clean, dry and intact, small old bruises on arms and no edema on feet. Resident refused skin check by this LN."</li> <li>* 5/8/16, "ST on right arm and left arm, resident refused skin check."</li> <li>* 5/15/15, "Resident skin is clean, very dry, and not intact. 1 skin tear on right elbow and 1 skin tear left arm. Both have treatments and are healing."</li> <li>* 5/22/16, WSC comments, "Resident skin is clean, dry and pink, along with very flaky. Heels firm and intact..."</li> <li>* 5/29/16, "Resident skin is clean, very dry and not intact. 4 old purple bruises right arm and 1 scabbed old skin tear covered with biotin and edema on lower bilateral extremities."</li> <li>* 6/5/16 "Residents skin is clean, very dry and not intact. 12 scabbed areas covered with biotin and 1 plus edema on lower bilateral extremities. Will continue to monitor." The section of WSC to document if Resident #3 had a new suspected pressure ulcer or DTI and/or new non-pressure</li> </ul>	F 314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 314	<p>Continued From page 10 related skin condition, was not completed.</p> <p>* 6/12/16, "Resident's skin is clean and dry with heels firm and not intact. Open areas to both heels covered with biotin that are clean, dry and intact."</p> <p>* 6/19/16, "Pressure areas to bilateral heels, senile purpura to bilateral forearms. Dry flaky skin from healed skin tears. No new skin issues noted from last skin check..."</p> <p>Resident's #3's Bates-Jensen Wound Assessment Tool (BWAT) contained spaces to document the date of each assessment, site, wound type, measurement in cm, stage, treatment/evaluation. The following were documented:</p> <p>* 6/1/16, Right ankle outer, Pressure, 2 cm x 2 cm x 0 cm, SDTI. "Initial assessment, heel lift boots placed and care planned for use in bed and w/c to protect skin."</p> <p>* 6/1/16, Left heel, Pressure, 1 cm x 1.3 cm x 0 cm, SDTI. "Initial assessment, heel lift boots placed and care planned for use in bed and w/c to protect skin."</p> <p>* 6/7/16, Right heel, Pressure, 3.2 cm x 6.8 cm x 0.2 cm, SDTI. "Assessed by wound team. Pain when cleaned with NS. R heel and malleolus areas have merged to current DTI. Purple in color. DTI has open area in center 0.2 cm x 0.2 cm, with small amount bloody drainage present. Wearing heel lift boots. Recommend tx [treatment] be changed to honey hydrogel covered with foam dressing."</p>	F 314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 314	<p>Continued From page 11</p> <p>* 6/7/16, Left heel, Pressure, 1.2 cm x 1.6 cm x 0 cm, SDTI, "Assessed by wound team. No change to appearance. Remains an intact DTI. Recommend no tx [treatment] change at this time. Continues to wear heel lift boots."</p> <p>* 6/21/16, Right heel, Pressure, 4 cm x 7 cm x 0.6 cm, Unstageable. "... 75% eschar and 25% slough. No granulation or epitheliazation. No recommendation to change orders at this time. Pain rated at 3/10 during treatment of area."</p> <p>* 6/21/16, Left heel, Pressure, 1.1 cm x 1.1 cm x 0 cm. SDTI. "...No treatment changes recommended at this time..."</p> <p>* 6/7/16 MAR documented, "Wound Care: Right Heel- apply honey hydrogel and cover with foam dressing, one time a day and PRN for wound care."</p> <p>On 6/23/16 at 9:40 am, the two Wound Nurses were interviewed regarding Resident #3's development of a SDTI. Wound Nurse #1 said they had provided Resident #3 with a pressure reducing mattress and w/c cushion upon admission. She said the heel lift boots were initiated when Resident #3's wound was discovered on 6/1/16. Wound Nurse #2 said the heel protectors were not provided upon admission because Resident #3's heels were assessed as firm with no skin impairment at that time. Wound Nurse #2 stated Resident #3 was being assisted with repositioning while in bed and his heels were being offloaded, as per their standard nursing practice.</p>	F 314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 314	Continued From page 12 On 6/23/16 at 10:55 am, the DON was asked about the development of SDTI and subsequent Stage 4 PU. The DON said it was difficult for them to determine the cause of the DTI due to Resident #3's behavior. She said Resident #3 could have kicked his w/c foot pedals during episodes of confusion, hallucinations, and agitations. The DON indicated Resident #3 was provided with heel protectors, but did not know for sure if he wore them daily. The DON said there was no documentation that Resident #3 kicked his w/c, but it was possible he kicked the w/c or other objects due to his behaviors. When asked if Resident #3's foot pain was assessed on 5/25/16 when he complained of pain and was reluctant to put feet on the floor, the DON said Resident #3's foot pain appeared to be neuropathy related and he was prescribed Gabapentin.  Resident #3 was harmed when the facility failed to ensure he wore heel protectors while in bed and in his w/c, after he was diagnosed with Peripheral Vascular Disease on 5/3/16. The facility did not implement new interventions to protect his skin, such as heel protection or offloading of his heels and did not implement the Podiatrist's instructions and recommendations to check Resident #3's feet daily, elevate his feet, and apply compression stockings.	F 314			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		7/28/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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	Continued From page 13  This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, it was determined the facility failed to ensure residents were protected from accidents during the provision of staff-assisted cares. This was true for 1 of 4 residents (#13) sampled for supervision and accidents. This deficient practice resulted in Resident #13 sustaining injuries due to falls occurring during Hoyer lift transfers. Findings include:  Resident #13 was admitted to the facility on 12/29/09 with diagnoses that included Alzheimer's Disease.  Physician Orders, dated 3/10/14, documented Resident #13's life expectancy was less than six months and she was placed on palliative care.  The 10/16/14 quarterly MDS assessment documented Resident #13 was totally dependent on at least two staff for transfers.  A Resident Event Report Worksheet, dated 1/2/15, documented Resident #13 sustained a laceration and hematoma to the left temple and a skin tear to the left elbow when she fell to the floor during a staff-assisted transfer via Hoyer mechanical lift.  The Event Worksheet documented, "During transfer resident slid through Hoyer sling and fell to floor hitting [left] shoulder [and left] side of	F 323	F 323 D " Resident #13 is no longer a resident at Aspen Park. " The SDC will educate licensed staff and direct care staff that two staff members are required to be present during any Hoyer transfer. Skilled competencies in Hoyer lift transfers are completed on hire and annually. " The SDC or designee will personally monitor 2 Hoyer lift transfers for correct sling use and two persons present weekly x 4 weeks, then 2 Hoyer lift transfers and correct sling use bi-weekly for 8 weeks. The PI committee will review audit results noted on the PI tool and take action as necessary and may adjust the frequency of monitoring after 12 weeks as it deems appropriate.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 14</p> <p>head ... improper use of Hoyer lift for transfer." Witness statements documented, "[CNA performing Hoyer transfer] asked me to get [Resident #13] up. I told her I had to get [another resident] ready, but would help [with] transfer when ready. She never came [and] got me."</p> <p>A hospital Emergency Department report, dated 1/2/15, documented, "[Resident #13] was being moved out of bed on a Hoyer lift this [morning] when she fell out and hit her left forehead on the floor with bruising. As this is the third time patient has slipped out of the Hoyer lift, another method for patient transfers needs to be found."</p> <p>A Nurse's Notes, dated 1/3/15, documented, "Bruise to left lat[eral] forehead dark purple with two small dry scabbed areas in center dry ... left lat[eral] elbow skin tear ..."</p> <p>A Nurse's Notes, dated 1/5/15, documented, "[Resident #13] had a significant fall on 1/2/15. [Resident #13] appears to be in more pain d/t [due to] fall."</p> <p>The facility's Mechanical Lift (Sling Lift) policy, dated 4/9/04, documented, "A mechanical lift allows two staff members to safely transfer a patient. A patient lift team consists of at least two employees working together to perform transfers, repositioning, or lifting tasks on generally high-risk patients."</p> <p>On 6/23/16, at 6:00 pm, the Administrator stated the CNA performing the Hoyer lift transfer of Resident #13 without assistance on 1/2/15 was terminated for not following facility policy.</p>	F 323			
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		7/28/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 SS=D	<p>Continued From page 15 <b>UNNECESSARY DRUGS</b></p> <p>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.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to accurately monitor and document a resident's behavior to ensure psychotropic medication was used with adequate indication. This was true for 1 of 3 (#3) residents sampled for psychotropic medication use. This deficient practice created the potential for harm when a resident received medications</p>	F 329	<p>F 329 D " A behavior monitor is in place for resident #3. " DNS or designee will complete a baseline audit on residents with a scheduled or PRN psychotropic medication to see that a behavior monitor is in place.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 16 without clear need or monitoring of his behaviors. Findings include:</p> <p>Resident #3 was admitted to the facility with multiple diagnoses including, pneumonia and weakness.</p> <p>Resident #3's 4/22/16 Admission MDS assessment documented he was severely impaired with a BIMS score of 4 and severely depressed with a PHQ-9 score of 23.</p> <p>Resident #3's care plan, dated 4/25/16, documented he was administered psychotropic medications related to behavior management, delusions, and thoughts of self harm. Interventions included: "Medications as ordered per MD, Monitor medication for side effects that may increase the risk for falls...Monitor/record occurrence of target behavior symptoms (Specify: pacing, wandering, disrobing, inappropriate response to verbal communication)."</p> <p>Resident #3's PN documented the following:</p> <p>*4/16/16, "Resident is alert and oriented with some confusion. He mentioned the TV screen becomes black when turned off..."</p> <p>*4/18/16, "...Said he couldn't eat because it's illegal, states he can't drive his car either, believes he has a car here..."</p> <p>*4/19/16 at 4:39 pm, "...Yelling and very angry. Removed penis from his attend and wanted it taken care of. Continued to yell wondered why the AD couldn't take of it..."</p>	F 329	<p>" The Clinical management team will review new psychotropic orders in the clinical meeting. When a scheduled or PRN psychotropic medication is ordered the team will validate that the behavior monitor is in place. SDC or designee will educate licensed nurses in initiating and documenting behavior monitoring for residents on scheduled or PRN psychotropic medications.</p> <p>" The social service director or designee will use a PI audit tool to review 5 residents weekly x 4 weeks then 5 residents bi weekly x 8 weeks. The PI committee will review audit results and take action as necessary and may adjust the frequency of monitoring after 12 weeks as it deems appropriate.</p>		

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

PRINTED: 08/02/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 17  *4/20/16 at 9:38 am, "Resident is refusing cares and medication on this shift. Resident is very hostile towards staff..."  *4/20/16 at 1:38 pm, "...Refused meds this shift. Stated it was unlawful to take pills..."  *4/20/16 at 11:33 pm, "...Asked resident would you like to take your medications? He replied, 'no I will tell you why there are these elves coming out of TV and they are not allowed in here'..."  *4/21/16 at 5:26 pm, "Made statements of pain after working with therapies. Said it would not matter if Dr. adjusted his pain meds as 'I will be dead by tomorrow anyway'...Refusing meds many times...Zyprexa PRN for delusional statements and s/sx of hallucinations..."  *4/22/16 at 6:40 am, "No statements of self harm..."  *4/23/16 at 4:07 am, "...No hallucinations noted this shift..."  *4/23/16 at 2:05 pm, "...No behaviors noted on day shift. Pleasantly confused during interaction. No verbal/physical combativeness or statements of hallucinations."  *4/27/16 at 3:30 pm, "...Had a few delusional statements in AM..."  *4/29/16 at 1:38 pm, "...Appeared to get agitated multiple times on shift regarding wanting something to drink and requesting orange juice. Was given orange juice, then stated 'what is	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 18</p> <p>this?' 'I want the hot drink.' In early AM had delusional statements, administered PRN Zyprexa with good effect..."</p> <p>*5/1/16 at 1:37 am, "Resident alert and oriented to person only. Some confusion noted...No hallucinations noted this shift"</p> <p>*5/2/16 at 3:03 pm, "Resident alert and pleasant, scheduled Tyl[enol] as ordered..."</p> <p>*5/3/16 at 3:08 pm, "Alert and pleasant, meds per order..."</p> <p>*5/4/16 at 8:49 am, "...No c/o foot pain/discomfort, no rash noted..."</p> <p>*5/5/16 at 2:02 pm, "Resident alert and pleasant. Took meds without incident. Denied pain..."</p> <p>*5/6/16 at 3:56 pm, "Resident oriented to self. Startled response when approached for cares or meds. Denies pain when questioned, moaning and loud vocalization when moved or repositioned. Cooperative with therapy without c/o discomfort..." Between 5/1/16 and 5/5/16 no behaviors were noted.</p> <p>On 5/6/16 at 12:40 pm, a Physician order request form documented, "...PRNs Zyprexa greatly helps his agitation, delusional statements when given. It has not been given at all so far this May and he has deteriorated in this time. Ok to schedule Zyprexa Zydis 5 mg PO daily?" The physician said "Yes."</p> <p>Resident #3's April 2016 MAR, included an order for Zyprexa 5 mg by mouth as needed for</p>	F 329			

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

PRINTED: 08/02/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 19 delusional statements and signs and symptoms of hallucinations. The MAR documented Resident #3 was administered Zyprexa 5 mg PRN on 4/21/16, 4/22/16, 4/25/16, 4/27/16, 4/28/16 and on 4/29/16.  Resident#3's May 2016 MAR, indicated the Zyprexa was not administered between 5/1/16 and 5/5/16.  On 6/22/16 at 2:10 pm, LN #4 was asked the reason Zyprexa was requested to be given as schedule on 5/6/16 when it was not given between 5/1/16 to 5/5/16. LN #4 said Resident #3 had deteriorated. When asked what she meant by deteriorated, LN#4 said he had some behaviors.  ON 6/23/16 at 10:55 am, the DON was asked about the behavior monitoring for Resident #3. The DON said she was not able to find the behavior monitoring data. Resident #3's behaviors were not documented as required in the care plan. Resident #3's record did not include documentation describing his behaviors, antecedents to the behaviors, staff's response or interventions initiated, and Resident #3's response to the interventions. Information necessary to determine potential causative factors and effective non-pharmaceutical interventions, was not documented.	F 329			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371		7/28/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 371	Continued From page 20 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure residents' food was stored in a manner that would help prevent contamination from airborne and/or contact contagions. This deficient practice created the potential for harm to residents who consumed potentially contaminated food. Findings include:  On 6/20/16 at 3:35 pm, with Day Cook #1 in attendance, an unsealed and undated plastic bag of frozen fish, and an unsealed and undated bag of pork, were observed in the facility's meat freezer. Both bags were gaping open and protruding from their own cardboard box.  When asked when the two bags had been opened, Day Cook #1 stated she did not know, but residents had been served fish the previous Friday. Day Cook #1 stated she did not know when the bag of frozen pork was opened or why neither bag had been resealed or dated.  Both bags of frozen food were disposed of into the facility's outdoor dumpster following the observation.	F 371	F 371 E  " The food in question was immediately disposed of. " DM validated food in the freezer was properly closed and dated. " DM or designee will educate culinary staff on policy in keeping frozen foods properly closed after being opened and indicating the date opened. " ED or designee will monitor freezer food handling compliance three times per week x 4 weeks then two bi-weekly x 8 weeks. The PI committee will review audit results and take action as necessary and may adjust the frequency of monitoring after 12 weeks as it deems appropriate.		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		7/28/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 431	<p>Continued From page 21</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it</p>	F 431			
			F 431 E		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 431	<p>Continued From page 22</p> <p>was determined the facility failed to ensure expired medications and two multidose bottles of Pneumovax were removed from the medication cart and medication room. This was true for 1 of 2 medications carts and 1 of 1 medication room checked for expired medications. This failed practice created the potential for residents to receive expired medications with decreased efficacy. Findings include:</p> <p>On 6/21/16 at 1:40 pm, during inspection of the 300 Hall Medication Cart with LN #3 present, the following expired medications were found:</p> <ul style="list-style-type: none"> <li>* 30 tablets of 2 mg Loperamide with an expiration date of 11/30/14</li> <li>* 11 tablets of 25 mg Meclizine with an expiration date of 10/31/14</li> <li>* 1 bottle of 500 mg Acetaminophen with an expiration date of 9/2015</li> <li>* 60 1/2 tablets of 12.5 mg Meclizine with an expiration date of 12/31/15</li> <li>* 30 tablets of 50 mg Sertraline with an expiration date 12/31/15</li> <li>* 1 bottle of 10 mg Cetirizine with an expiration date of 2/16</li> <li>* 30 tablets of 1 mg Haloperidol with an expiration date of 2/2016</li> <li>* 20 tablets of 1 mg Haloperidol with an expiration date of 4/2016</li> </ul>	F 431	<ul style="list-style-type: none"> <li>" Expired medications that were found have been properly destroyed.</li> <li>" DNS or designee completed an audit of the expiration dates of the medications in each cart and medication room. Expired medications removed as needed.</li> <li>" SDC or designee will educate licensed staff and pharmacy consultant, but not limited to, in evaluating the expiration dates of medication located in the medication carts and medication room.</li> <li>" The DNS or designee will utilize a PI tool to conduct review of medication expiration dates for medications in the med carts and med room. These will be completed monthly x 3. The PI committee will review audit results and take action as necessary and may adjust the frequency of monitoring after 12 weeks as it deems appropriate.</li> </ul>		

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

PRINTED: 08/02/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - ASPEN PARK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>		
(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 431	<p>Continued From page 23</p> <ul style="list-style-type: none"> <li>* 15 tablets of 2 mg Loperamide with an expiration date of 4/9/16</li> <li>* 1 bottle of 500 mgs Chewable Vit C with an expiration date of 4/2016</li> <li>* 1 bottle of 75 mg Ranitidine with an expiration date of 4/2016</li> </ul> <p>LN #3 confirmed the expiration dates and said the medications would be discarded.</p> <p>On 6/21/16 at 2:20 pm, during the inspection of the medication room with RN consultant present, the following were found:</p> <ul style="list-style-type: none"> <li>* 2 vials of multidose Pneumovax with an expiration date of 5/2016</li> <li>* 3 tablets of 10-325 mg Oxycodone Acetaminophen with an expiration date of 5/2016</li> </ul> <p>The RN consultant confirmed the expiration dates and said the medications would be destroyed.</p>	F 431			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001500</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - A</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>
---	--

(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>The following deficiencies were cited during the State Licensure and complaint investigation survey of your facility. The survey team entered the facility on 4/2016 and exited on 4/23/16.</p> <p>The surveyors conducting the survey were:</p> <p>Presie C. Billington, RN - Team Coordinator David Scott, RN Jenny Walker, RN</p> <p>Acronyms used in this report include: ICC - Infection Control Committee</p>	C 000		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on review of the Infection Control Meeting Minutes and staff interview, it was determined the facility failed to ensure a representative from required departments attended Infection Control Meetings. This affected 13 of 13 sampled residents (#s 1-13) and all residents who resided in the facility. Findings included:</p> <p>The February 2016 through June 2016 Infection Control Minutes documented the dietary services supervisor was not in attendance.</p> <p>On 6/23/16 at 6:30 pm, the Administrator was informed of the identified concern.</p>	C 664	<p>C 664 (Idaho)</p> <p>" The ED educated the DM that DM or designee must attend the monthly infection control/PI meeting.</p> <p>" ED educated each department in the infection control/PI meeting process and the required signatures of attendance.</p> <p>" ED will validate each department representative has signed the signature log after PI meetings. The ED will monitor the infection control/PI meeting signature logs monthly for three months to assure that those in attendance have signed. This will be monitored monthly x</p>	7/28/16

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  07/18/16
--	-------	---------------------------

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001500</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/23/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - A</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 ROWE STREET MOSCOW, ID 83843</b>
---	--

(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 664	Continued From page 1	C 664	3 months. The PI committee will review for compliance and take action as necessary and may adjust the frequency of monitoring after 12 weeks as it deems appropriate.	



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](mailto:fsb@dhw.idaho.gov)

July 14, 2016

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

Provider #: 135093

Dear Mr. Farnes:

On **June 23, 2016**, an unannounced on-site complaint survey was conducted at Kindred Nursing & Rehabilitation - Aspen Park. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

**Complaint #ID00007238**

The complaint was investigated during the facility's on-site Federal Recertification and Complaint Investigation and State Licensure survey conducted July 20, 2016 through July 23, 2016.

The survey team conducted a tour of the facility, including resident rooms, immediately after entering the facility on June 20, 2016 and the residents' environment was observed throughout the survey. Fifteen residents, including those residents associated with this complaint where possible, were observed for quality of life and quality of care issues during the survey. The closed records of those residents not residing in the facility at the time of survey were reviewed.

In addition, the facility's grievances files, incident and accident reports, investigations of allegations of abuse, and staffing records were also reviewed and a group interview was conducted with residents to elicit and investigate any concerns brought forth through that process. Interviews were also conducted with individual residents, family members or interested parties of residents, the Administrator, Director of Nursing, Registered Dietician, Maintenance Director, nurses, and nurse aides.

**Allegation#1:** The Reporting Party stated there is insufficient staffing in the building to respond to call lights on either day- or night shift. This inadequate level of staffing has left residents waiting extended periods of time for assistance, led to unsafe practices (mechanical transfers using only one- rather than two staff), staff unable to observe basic hygiene, such as handwashing, beds left unmade, etc.

**Findings #1:** Staffing records were also reviewed for the time frame in question, as well as the three week staffing schedule for the period immediately preceding the annual recertification and complaint survey. Staff response to call lights were observed throughout survey.

Based on observation, interviews, record reviews, and a review of staffing levels prior to- and during survey, this allegation could not be substantiated for lack of evidence.

**Conclusion #1:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** The Reporting Party stated there was hole in the wall next to a bed in Room 316.

**Findings #2:** This allegation was substantiated and cited during the facility's federal recertification and state licensure survey. Please refer to Federal Report 2567 for details.

**Conclusion #2:** Substantiated. Federal deficiencies related to the allegation are cited.

**Allegation #3:** The Reporting Party stated many beds in the facility were located next to heaters in resident rooms, creating a fire hazard if blankets came into contact with the heater.

**Findings #3:** Beds with blankets in contact with heaters were observed in rooms 106, 107, 108, 210, 301, 303, 305, 306, 307, and 308. The facility's resident room heaters, however, are operated by steam and covered with a shield to protect residents from direct contact. This system does not present a fire hazard and the allegation was not substantiated.

**Conclusion #3:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #4:** The Reporting Party stated the bathroom heater casing between rooms 302 and 304 was completely detached from the wall and in need of repair or replacement.

**Findings #4:** The bathroom heater between rooms 302 and 304 was examined by surveyors and the Maintenance Director. The heater's shield was designed in a way to disassemble readily for maintenance and repair. The shield was not improperly installed or poorly maintained, but did require monitoring to avoid a potential skin tear- and trip hazard. The Maintenance Director stated the heater would be added to the facility's routine maintenance schedule to ensure resident safety.

**Conclusion #4:** Unsubstantiated. Lack of sufficient evidence.

David Farnes, Administrator  
July 14, 2016  
Page 3 of 3

**Allegation #5:** The Reporting Party stated cords draped near the sink in Room 305 created an electrical-shock hazard.

**Findings #5:** Surveyors observed a charger near the sink in Room 305, however during each observation the cord was well clear of the sink and plugged into an outlet protected with a ground fault circuit interrupter. This allegation was not substantiated for lack of evidence.

**Conclusion #5:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #6:** The Reporting Party stated several sinks in resident rooms had water faucets that did not turn off and that this discouraged residents from washing their hands and were potentially annoying to the residents in those rooms.

**Findings #6:** The sinks in each room were observed during initial tour and periodically throughout the facility's survey. Residents were also questioned during individual- and group interviews and no issues of concern were identified either through observation or interview. This allegation is not substantiated for lack of evidence.

**Conclusion #6:** Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

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