



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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September 08, 2016

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

Provider #: 135093

Dear Mr. Farnes:

On August 23, 2016, we conducted an on-site revisit to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **July 28, 2016**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

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.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 18, 2016**.

David Farnes, Administrator

September 8, 2016

Page 2 of 3

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.
- 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*.

As noted in the Bureau of Facility Standards' letter of **July 8, 2016**, following the survey of **June 23, 2016**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **December 23, 2016**, if substantial compliance is not achieved by that time. The findings of non-compliance on , has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On **August 5, 2016**, CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after **September 21, 2016**
- A 'per instance' civil money penalty of **\$1,500.00 per instance for the instance on June 23, 2016 described at deficiency F0314 (S/S: G)**

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

David Farnes, Administrator

September 8, 2016

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If you believe the 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, 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **September 18, 2016**. If your request for informal dispute resolution is received after **September 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/pmt
Enclosures

David Farnes, Administrator
September 8, 2016
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/19/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/23/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - ASPEN PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 420 ROWE STREET MOSCOW, ID 83843		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS The following deficiency was cited during the follow up to a recertification survey of your facility conducted 8/22/16 through 8/23/16. The surveyors conducting the survey were: Linda Kelly, RN - Team Coordinator Teresa Kobza, RDN, LD Acronyms used in this report include: BWAT = Bates-Jensen Wound Status Tool cm = Centimeter CNA = Certified nursing assistant DM = Diabetes Mellitus DTI = Deep Tissue injury MD = Physician MDS = Minimum data set OT = Occupational Therapy PRN = As Needed x = by w/c = Wheelchair	{F 000}			
{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.	{F 314}		9/20/16	

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

TITLE

(X6) DATE

Electronically Signed

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

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{F 314}	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, it was determined the facility failed to ensure a resident who entered the facility with a pressure ulcer and with known history of pressure ulcers, remained free from recurrent pressure ulcers. This was true for 1 of 6 (#17) residents sampled for pressure ulcers. Resident #17 was harmed when he re-developed a stage II pressure ulcer while in the facility. Findings include:</p> <p>Resident #17 was admitted to the facility on 11/5/14 with multiple diagnoses including DM Type II, peripheral vascular disease, and osteoarthritis.</p> <p>Resident #17's 7/28/16 Quarterly MDS assessment documented he had a fluid filled blister to the right heel and staff was instructed to continue heel boots at all times, except during showers, and his mattress was changed to an alternating air mattress.</p> <p>Resident #17's Skin Alteration Care Plan documented:</p> <p>* Resident #17 had actual impairments to his skin integrity related to a blister on his right heel. In addition, Resident #17 was at risk for impaired skin integrity related to elderly status, fragile skin, a history of pressure ulcers and itching. This was initiated on 11/6/14. The plan was revised on 8/22/16 to reflect the blister to his right heel. Interventions included:</p> <p>* Staff was to apply lift heel boots to both heels,</p>	{F 314}	<p>F314</p> <p>An updated Braden scale predictive index has been completed and Care Plan updated as appropriate for resident #17. Skin has been assessed and Care Plan updated for Res #17. The therapy department has evaluated the resident. Interventions for pressure relieving devices or other recommendations have been reviewed by the clinical team and implemented as appropriate.</p> <p>Residents at risk have had an updated Braden Scale for Predicting Pressure Ulcer Assessment completed. Those at high risk will be reviewed by the wound care team and when appropriate, will have interventions in place to reduce risk of developing pressure ulcers. The clinical management team will review these recommendations along with a review of the residents' diagnosis and coordinate the overall care plan for the resident. The clinical management team will review the Braden Scale, skin assessments, diagnosis and cognitive status for each resident upon admission. Implementation of pressure reducing devices or other recommendations will be use as appropriate. A base line audit of interventions for other residents with a Braden Scale at Risk, Moderate or High risk for pressure ulcers have been evaluated, adjustments to treatment plan have been implemented where</p>		

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{F 314}	<p>Continued From page 2 revised on 6/10/16.</p> <ul style="list-style-type: none"> * Resident #17 needed an extra-long pressure relieving mattress, revised on 8/1/16. * Resident #17 needed a pressure reducing w/c cushion to protect his skin, which was initiated on 2/25/15. * Resident #17 was to have a sheep skin padding on his w/c brakes, initiated 8/22/16. * Staff was to provide treatment, to the right heel, per physician orders, initiated 8/1/16. * Staff was instructed to help assist Resident #17 with turning and repositioning during rounds and PRN, initiated 6/10/16. <p>Resident #17's August 2016 Physician Orders through 8/22/16 documented staff was instructed to paint iodine to his right heel and cover with a foam dressing until it is healed, one time a day and PRN, beginning 7/30/16.</p> <p>A 5/28/16 Weekly Pressure Ulcer BWAT Report documented Resident #17 had a right heel pressure ulcer that had healed. In addition, the note documented the wound had been first discovered on 3/17/16.</p> <p>On 7/20/16 the facility had an All Staff Meeting during which proper placements of positioning devices were discussed. The meeting minutes documented staff was to ensure boots were put on residents' feet properly, to avoid and prevent pressure related injuries.</p>	{F 314}	<p>appropriate.</p> <p>Education has been provided to licensed nursing staff and nursing assistants on how to use pressure reducing equipment including heel lift mats and pressure offloading boots. Nurses are responsible to monitor the proper utilization of the interventions per the plan of care. The clinical management team will review the communication report and the 24 hour report from the medical record in clinical meeting. Resident's identified with a change in condition will be reviewed for appropriate pressure ulcer interventions.</p> <p>The clinical management team will use a PI audit tool to review new admissions for high Braden scores, implement interventions as deemed appropriate and per the plan of care. Current residents will be monitored and weekly audit completed to assure the interventions are in place and effective.</p> <p>Results of the audits will be presented monthly to the facility Performance Improvement Committee. Recommendations will be addressed with the PI committee. Audits will be reviewed monthly for 3 months, then periodically thereafter.</p> <p>DNS responsible to assure compliance.</p>		

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{F 314}	<p>Continued From page 3</p> <p>A 7/28/16 Nursing Incident Note documented Resident #17 had a 3.5 x 3.3 cm fluid filled blister to his right heel.</p> <p>A 7/28/16 Weekly Pressure Ulcer BWAT Report documented Resident #17 had a stage II pressure ulcer to his right heel which measured 3.5 x 3.3 cm.</p> <p>A 7/28/16 Pressure Ulcer Investigation documented Resident #17 had developed a stage II pressure ulcer to his right heel. The following reasons were given for why it was an unavoidable pressure ulcer:</p> <ul style="list-style-type: none"> * Resident #17 had multiple diagnoses and a history of pressure ulcers which predisposed him to developing them. * Resident #17 was on a pressure reducing mattress and had mobility devices to help him move. * Resident #17 was turned and repositioned by nursing staff per his care plan. * Resident #17 was monitored quarterly by the dietitian for his nutrition needs. <p>The investigation report did not mention Resident #17's heel boots.</p> <p>A 8/1/16 Nurses' Note documented the facility planned to pad the front end of Resident #17's right heel boot to help with his foot positioning.</p> <p>An 8/2/16 Pressure Ulcer BWAT Report documented Resident #17 had a pressure ulcer</p>	{F 314}		

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{F 314}	<p>Continued From page 4</p> <p>to his right heel suspected to be related to a DTI, which measured 3.8 x 5.2 cm. In addition, the report documented the wound was assessed by the wound team and the current treatment of iodine with foam dressing was to be continued and the staff planned on re-evaluating his heel lift boots for proper fit.</p> <p>An 8/9/16 Pressure Ulcer BWAT Report documented Resident #17 had a stage II pressure ulcer to his right heel suspected to be related to a DTI, which measured 3.8 x 4.6 cm.</p> <p>An 8/17/16 Pressure Ulcer BWAT Report documented Resident #17 had an unstageable pressure ulcer to his right heel, which measured 3.7 x 4.6 cm. In addition, the report documented the wound had hardened into 100% eschar (dry scab).</p> <p>On 8/23/16 at 11:20 am, the two Wound Nurses were interviewed regarding Resident #17's development of a stage II pressure ulcer which progressed into a unstageable pressure ulcer. Wound Nurse #2 stated they looked into every possible situation for the reason of the pressure sore, to include looking at the proper position of the boots on his feet and if his heels were sticking out of the boots and rubbing against his w/c. Wound Nurse #1 stated the facility asked for a therapy evaluation of Resident #17's w/c and re-educated CNA's to ensure his heel was not sticking out of the heel boot opening. Documentation of a therapy evaluation and the CNA re-education, were not in Resident #17's record or provided by the facility. Wound Nurse #1 stated they had modified special boots with extra foam taken out of the heel of the right boot</p>	{F 314}			

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{F 314}	<p>Continued From page 5 to allow it to float freely.</p> <p>On 8/23/16 at 11:30 am, Wound Nurse #1 and Wound Nurse #2 entered Resident #17's room and removed the boots from both of his feet. The foam cushions along the back of the boots were the same and there were no visible markings on the boots, designating the right verses the left boot. Wound Nurse #2 stated she remembered the staff modifying the foam on the heel of the right boot.</p> <p>On 8/23/16 at 11:30 am, Resident #17 stated he did not remember having any other boots.</p> <p>On 8/23/16 at 3:00 pm, Wound Nurse #1 stated the heel lift boots that were modified for Resident #17 were sent to the laundry and they were not marked left verses right or with Resident #17's name. She stated she would revise the care plan and label the boots.</p> <p>A physician order, dated 8/23/16 at 3:10 pm, documented, "Ensure heel lift boots are placed properly to left and right heel (boots are labeled)." Resident #17's care plan was updated on 8/23/16 and documented, "heel lift boots to be in place at all times in bed [and] w/c. Boots are labeled left and right specifically related to custom modifications."</p>	{F 314}			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001500	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/23/2016
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - A	STREET ADDRESS, CITY, STATE, ZIP CODE 420 ROWE STREET MOSCOW, ID 83843
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{C 000}	<p>16.03.02 INITIAL COMMENTS</p> <p>A follow-up survey was conducted on 8/23/16. The facility was found to be in substantial compliance with state licensure requirements.</p>	{C 000}		

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

TITLE

(X6) DATE