



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

October 6, 2016

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

Provider #: 135021

Dear Ms. Freeze:

On **September 22, 2016**, a survey was conducted at Kindred Transitional Care And Rehab - Lewiston by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

Debbie Freeze, Administrator
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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 **October 17, 2016**. Failure to submit an acceptable PoC by **October 17, 2016**, may result in the imposition of penalties by **November 1, 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 **October 27, 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 **December 21, 2016**. A change in the seriousness of the deficiencies on **November 6, 2016**, may result in a change in the remedy.

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

Denial of payment for new admissions effective **December 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 **March 21, 2017**, 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 **December 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:

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

Debbie Freeze, Administrator

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

- BFS Letters (06/30/11)

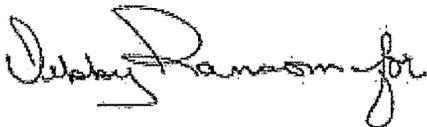
2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **October 17, 2016**. If your request for informal dispute resolution is received after **October 17, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in black ink, appearing to read "David Scott for". The signature is written in a cursive style with a horizontal line under the first name.

David Scott, RN, Supervisor
Long Term Care

DS/pmt
Enclosures

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

PRINTED: 10/06/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/22/2016
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB - LEWISTON	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from September 19, 2016 to September 22, 2016.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Sheila Sizemore, RN Marcia Mital, RN</p> <p>Survey Definitions: CNA = Certified Nursing Aide CVA = Cerebrovascular Accident (stroke) D/C = discontinue DNS = Director of Nursing Services DX = Diagnosis HS = Hour of Sleep L = left LN = Licensed Nurse MD = Medical Doctor MDS = Minimum Data Set assessment mg = milligram NOC = night PO = by mouth POA = Power of Attorney PRN = As Needed q = every R = right RN = Registered Nurse r/t = related to TX = treatment w/ = with</p>	F 000	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Transitional Care and Rehabilitation does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>F225</p> <p>Resident Specific: this facility reviewed resident #5's investigation, The ED interviewed staff members that were involved and obtained written statements. Investigation has been completed.</p> <p>Other Residents/ investigative report: this facility will complete a 6 month baseline audit of other investigative reports related to injuries of unknown origin to ensure they are complete with content, written interviews, and conclusion were valid. Education done with staff regarding investigative procedure and protocols by ED.</p>	10/27-16
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		

RECEIVED
OCT 27 2016
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debbie Kege TITLE: Executive Director (X6) DATE: 10/14-16

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 225	Continued From page 1 The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 225	Facility Systems: Other injuries of unknown origin and investigations will be reviewed by the Executive Director and DDCO. The Executive Director was educated in completion of investigations of unknown origin. Executive Director will educate staff to but not limited to : staff will be directed to ensure statements are received in writing from primary staff, resident if able, roommate, and family if able at the time of the event. MONITOR Monitor will be completed by ED and oversight of DDCO with investigations of injury of unknown origin or allegation of abuse. Two investigations will be reviewed weekly x 4, then 2 investigations bi-weekly x 1 month then 2 investigations monthly x 1 month. PI monitor monthly 3 months and then quarterly starting with Oct PI meeting audit will be done by ED		

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F 225	<p>Continued From page 2</p> <p>Based on family member and staff interviews and review of residents' clinical records, facility policy, facility investigations, staffing schedules, and hospital records, it was determined the facility failed to ensure a thorough investigation was completed when a resident sustained an injury of unknown origin resulting in a fracture. This was true for 1 of 15 sampled residents (Resident #5). The lack of thorough investigation created the potential for abuse to go undetected and Resident #5 to experience further injuries. Findings include:</p> <p>A current facility policy, Conducting an Investigation, dated 6/30/16, was received from the Administrator on 9/20/16 at 3:10 pm. The policy included:</p> <p>* "The Investigation... Unusual Occurrences... Document the details of the incident... Interview staff members, visitors, and/or residents who may have knowledge of alleged incident being investigated. Interviews may include:</p> <ul style="list-style-type: none"> - Staff that provided care to the resident(s) at the time the alleged incident. - Staff on other shifts who may have seen or heard anything 24 hours prior to the alleged incident, to try and narrow down the time frame of the alleged occurrence and to document when the first sign any injury may have appeared. - Residents in the same room, or residents in the immediate vicinity or where the alleged incident occurred who might have seen or heard something... <p>* Review the center's procedures if the incident is related to unsafe technique used by the staff."</p>	F 225			

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F 225	<p>Continued From page 3</p> <p>Resident #5's record included diagnoses of Alzheimer's disease and non-displaced femoral condyle (fracture at the knee joint of the femur).</p> <p>Resident #5's annual MDS assessment, dated 1/12/16, documented she had long and short term memory problems, and her decision-making ability was severely impaired. The assessment noted Resident #5 was dependent upon staff for bed mobility, required extensive assistance of staff for transfers, and was not ambulatory.</p> <p>Resident #5's current care plan documented "Physical Mobility impaired r/t (related to) pain... Transfer with sit to stand machine. Provide extensive assistance and verbal cueing."</p> <p>Resident #5's progress notes, dated 3/4/16, documented:</p> <p>* 9:32 am - "Send to (hospital) for eval[uation] and tx for R knee: swollen, red, immobile. DX Possible cellulitis. Attempted to call all daughters without answer, without answer left message with POA."</p> <p>* 1:44 pm - "Per MD sent to (hospital) r/t R knee pain. Family was notified at (9:30 am), talked to (name of physician) on phone at (9:20 am) Resident was transported via non-emergent transportation. Resident returned at (12:40 pm)."</p> <p>The hospital's Emergency Department Note, dated 3/4/16, documented:</p> <p>* "Chief Complaint: Pain, Knee... Initial comments: female who presents to the emergency department for evaluation of above chief complaint. Patient has been experiencing</p>	F 225		

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F 225	Continued From page 4 right knee pain. Patient has dementia and cannot provide any further information. There are no reports of fever or trauma. Patient has prior knee surgery. * Comments: Right knee. There is mild swelling there is no erythema (redness) or warmth to touch. I cannot elicit any tenderness to palpation. Ranging the knee causes pain. * Notes: X-ray of right knee shows a femur fracture... Orthopedic surgery recommended the patient is placed in a knee immobilizer and be made nonweightbearing [sic] on the right leg." * Right knee x-ray findings included, "Findings... view of the right knee show a total knee prosthesis. There is a fracture in the medial femoral condyle." The facility's investigation, provided by the Administrator on 9/20/16 at 2:45 pm, documented: * The date as 3/4/16 and primary caregivers at time of event were LN #1, CNA #2, CNA #3, CNA #7. * Employees who cared for Resident #5 during the 48 hours prior to 3/4/16 included LN #1, LN #3, LN #4, LN #5, CNA #2, CNA #3, CNA #4, CNA #5, and CNA #6. * The investigation included statements from 6 of the 10 staff identified as primary caregivers at the time of the event or who cared for Resident #5 within the 48 hours prior to it. Statements were not garnered from 4 of the 10 staff; LN #3, CNA #3, CNA #4, and CNA #5.	F 225		

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F 225	Continued From page 5 * Skin issues were documented as "...R knee swollen, red, L leg w/ slight bruising... Transfer Status Assist of Two. Transfer Equipment Sit/Stand..." * Investigative interviews completed included a Primary Caregiver Statement from LN #1. The statement described the event as "CNA's reported resident w/R knee pain. Gave scheduled APAP (Tylenol) (for) arthritis. Once in shower CNA called me to look. Knee (R) was swollen warm and pain noted Called [sic] (Physician name), sent to (hospital)." * CNA #2's statement noted Resident #5 "...wasn't standing into sit-to-stand & appeared to be in pain. When we went to get her up, she was holding knee up. After up she wouldn't relax knee, and noticed knee/foot swollen. Notified RN." * CNA #7's statement included "Last showered (Tues) no noted issues with R knee, today knee (R) was swollen and noticed bruising to L leg. Notified RN." * The investigation did not include statements from residents. An Investigation Conclusions & Plan for Prevention, received from the Administrator on 9/20/16 at 2:45 pm, documented "Investigation & Conclusion: Upon investigation, record review and interviews it was determined that on 03/04/16 the resident complained of pain in her L knee [sic was right knee] during morning cares. The Aide reported to the RN, where upon examination she found the knee to be warm to touch, red, painful,"	F 225			

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F 225	<p>Continued From page 6</p> <p>with initial bruising... Interviews of aides revealed that the resident's shower was completed on 3/1/2016 [and she] did not show any signs of redness or swelling to the legs. Staff who worked the prior 24-hours was interviewed without evidence of complaints of pain by the resident... The morning of 03/04/2016 was the first identified change. Upon re-enactment the placement of bruise and fracture aligns with the bar on the sit-to-stand apparatus that the patient could come in contact with should the patients [sic] knee buckle. Based upon the age of bruising, swelling, and pain it is determined that the injury occurred the prior evening during transfer to bed. Resident history does show L [sic] knee replacement."</p> <p>Resident #5's family member was interviewed on 9/21/16 at 1:25 pm. The family member stated s/he had been at the facility on 3/3/16 until about 6:30 or 7:00 pm and Resident #5 had been fine.</p> <p>Staff schedules for 3/3/16, provided by the nurse consultant on 9/21/16 at 10:07 am, showed CNA #9 and CNA #10 also worked the afternoon shift on 3/3/16 and CNA #10 worked the night shift on 3/3/16. The investigation did not include statements from CNA #9 and CNA #10.</p> <p>During an interview on 9/20/16 at 3:07 pm, the Administrator stated CNA #7 worked the evening before the fracture was discovered on 3/4/16. She indicated CNA #7 had assisted Resident #5 to bed the evening before and CNA #7 reported nothing unusual occurred when she transferred Resident #5 to bed.</p> <p>During an interview on 9/20/16 at 4:25 pm, the Administrator stated CNA #5 worked with CNA #7 the evening shift on 3/3/16. The Administrator</p>	F 225			

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F 225	Continued From page 7 said she was going to talk to CNA #5 and did not recall taking a statement from CNA #5. She stated she would also talk to the nurse who worked the evening shift on 3/3/16. The Administrator commented she had spoken to the evening shift nurse before, but did not document it. During an interview on 9/21/16 at 10:07 am, the Nurse Consultant stated the daily staff schedule and the monthly staff schedule did not match. She said the list of employees who worked with Resident #5 on 3/3/16 did not match. She said CNA #5 did not work on 3/3/16 and CNA #9 did work. She said it was getting more confusing and she was not sure who assisted CNA #6 when Resident #5 was transferred to bed on 3/3/16. During an interview on 9/21/16 at 11:20 am, the Administrator stated she had probably left some things out of the investigation report, but she had been able to rule out abuse.	F 225	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Transitional Care and Rehabilitation does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of residents' clinical records, facility policy, facility investigations, staffing schedules, personnel files, and hospital records, it was determined the	F 226	Resident Specific The facility reviewed employee A's file and found that proper supporting documentation including a background check was appropriately placed in the file. A copy of the background check for employee A was placed in employee file. Other Residents Ensure that personnel files include proper documentation of background checks, licensure, certifications and registrations.	10/27-16	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	<p>Continued From page 8</p> <p>facility failed to ensure the facility's policy related to investigations of injuries of unknown origin was followed when a resident sustained a fracture of unknown origin. This failure directly impacted 1 of 15 sampled residents (Resident #5). The facility also failed to ensure its policy related to new employee background checks was followed for 1 of 3 CNAs (Employee A) whose employee files were reviewed. This created the potential for abuse to go undetected, Resident #5 to sustain further injury, and the hiring of CNAs with a history of abuse and/or neglect. Findings include:</p> <p>1. A current facility policy, Conducting an investigation, dated 6/30/16, was received from the Administrator on 9/20/16 at 3:10 pm. The policy stated "The Investigation... Unusual Occurrences... Document the details of the incident... Interview staff members, visitors, and/or residents who may have knowledge of alleged incident being investigated. Interviews may include:</p> <ul style="list-style-type: none"> - Staff that provided care to the resident(s) at the time the alleged incident. - Staff on other shifts who may have seen or heard anything 24 hours prior to the alleged incident, to try and narrow down the time frame of the alleged occurrence and to document when the first sign any injury may have appeared. - Residents in the same room, or residents in the immediate vicinity or where the alleged incident occurred who might have seen or heard something... <p>Resident #5's annual MDS assessment, dated 1/12/16, documented she had long and short term memory problems, and her decision-making ability was severely impaired. The assessment</p>	F 226	<p>Facility Systems Human Resources department was trained by ED in documents needed for employee files. Systems to be put in place include reviewing employee files to ensure, background checks, and registry verifications are in place.</p> <p>Monitor Monitoring will include having the SDC or designee will monitor appropriate documents of background checks, licensure, certifications and registrations of employees are in their files when reviewed. The audit will be completed weekly x 4 for new hire employee files, then bi-weekly x 1 month then monthly x 1.</p> <p>PI monitor monthly x 3 months then quarterly beginning with October PI meeting, audit will be completed by SDC</p>		

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F 226	<p>Continued From page 9</p> <p>noted Resident #5 was dependent on staff for bed mobility, required extensive assistance of staff for transfers, and was not ambulatory.</p> <p>Resident #5's current care plan documented "Physical Mobility impaired r/t (related to) pain... Transfer with sit to stand machine. Provide extensive assistance and verbal cueing."</p> <p>Resident #5's progress notes, dated 3/4/16, documented:</p> <p>* 9:32 am - "Send to (hospital) for eval[uation] and tx for R knee: swollen, red, immobile. DX Possible cellulitis. Attempted to call all daughters without answer, without answer left message with POA."</p> <p>* 1:44 pm - "Per MD sent to (hospital) r/t R knee pain. Family was notified at (9:30 am), talked to (name of physician) on phone at (9:20 am) Resident was transported via non-emergent transportation. Resident returned at (12:40 pm)."</p> <p>The hospital's Emergency Department Note, dated 3/4/16, documented:</p> <p>* "Chief Complaint: Pain, Knee... Initial comments: female who presents to the emergency department for evaluation of above chief complaint. Patient has been experiencing right knee pain. Patient has dementia and cannot provide any further information. There are no reports of fever or trauma. Patient has prior knee surgery.</p> <p>* Comments: Right knee. There is mild swelling there is no erythema (redness) or warmth to touch. I cannot elicit any tenderness to palpation.</p>	F 226			

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB - LEWISTON	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501
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F 226	Continued From page 10 Ranging the knee causes pain. * Notes: X-ray of right knee shows a femur fracture... Orthopedic surgery recommended the patient is placed in a knee immobilizer and be made nonweightbearing [sic] on the right leg." * Right knee x-ray findings included, "Findings... view of the right knee show a total knee prosthesis. There is a fracture in the medial femoral condyle." The facility's investigation of the incident, provided by the Administrator on 9/20/16 at 2:45 pm, documented: * Primary caregivers at time of event were LN #1, CNA #2, CNA #3, and CNA #7. * "List of Employees who cared for the resident in the last 48 hours [prior to 3/4/16]" included LN #1, LN #3, LN #4, LN #5, CNA #2, CNA #3, CNA #4, CNA #5, and CNA #6. * The investigation included statements from 6 of the 10 staff identified as primary caregivers at the time of the event or who cared for Resident #5 within the 48 hours prior to it. Statements were not garnered from 4 of the 10 staff; LN #3, CNA #3, CNA #4, and CNA #5. * The investigation did not include statements from residents. Staff schedules for 3/3/16, provided by the nurse consultant on 9/21/16 at 10:07 am, showed CNA #9 and CNA #10 also worked the afternoon shift on 3/3/16, and CNA #10 worked the night shift on 3/3/16. The investigation did not include	F 226		
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F 226	<p>Continued From page 11 statements from CNA #9 and CNA #10.</p> <p>During an interview on 9/20/16 at 4:25 pm, the Administrator stated CNA #5 worked with CNA #7 the evening shift on 3/3/16. The Administrator indicated she was going to talk to CNA #5 and did not recall taking a statement from CNA #5. She indicated she would also talk to the nurse who worked the evening shift on 3/3/16. The Administrator commented she had spoken to the evening shift nurse before, but did not document it.</p> <p>During an interview on 9/21/16 at 10:07 am, the Nurse Consultant stated the daily staff schedule and the monthly staff schedule did not match. She said the list of employees who worked with Resident #5 on 3/3/16 did not match. She said CNA #5 did not work on 3/3/16 and CNA #9 did work. She said it was getting more confusing and she was not sure who assisted CNA #6 when Resident #5 was transferred to bed on 3/3/16.</p> <p>2. The facility's current abuse policy and procedures, dated 4/28/11, documented the following under the section Employee Background & Screening: "Professional licensure, certification, and/or registration are checked pre-employment, annually...and upon renewal."</p> <p>The facility's hiring list documented Employee A was hired on 8/3/16. Employee A's nurse aide employee personnel file was reviewed for the State Nurse Aide Registry Verification Report and none was found.</p> <p>On 9/22/16 at 1:55 pm, the Human Resource/Payroll Administrator said she could not find the registry check and provided the surveyor</p>	F 226			

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F 226	Continued From page 12 with a copy of the registry check performed that day (9/22/16), which did not identify abuse findings for Employee A.	F 226			
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Transitional Care and Rehabilitation does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. F272 Resident Specific The assessment resident # 6 to ensure correct documentation reflects current status. Resident number 6 is discharged. Resident number 10's assessment was updated to validate IV status. Other Residents The facility will Review other residents deemed "smokers" and ensure that assessments are correct and reflect their current status.	10/27-16	

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F 272	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, it was determined the facility failed to ensure residents were assessed as safe to smoke without staff supervision and had accurate assessments for a port-a-cath. This was true for 2 of 15 (#6 & #10) sampled residents. These failures created the potential for harm if residents were not accurately assessed for smoking safety or residents central venous catheter were improperly cared for. Findings include: 1. The facility's Smoking Policy, dated 7/22/11, documented: "Determine the patient's independence and/or dependence with smoking ability and the need for protective gear upon admission... with a significant change or as needed..." Resident #6 was admitted to the facility on 8/9/16, with multiple diagnoses, including Parkinson's disease and weakness. Resident #6's 8/10/16 Smoking Evaluation documented he was a dependent smoker with the need for protective gear such as a smoking apron or smoking gloves and he "did not wish to smoke at this time." On 9/20/16 at 9:30 am and 4:03 pm, Resident #6 was observed smoking in the designated	F 272	The facility will verify other residents in house with an IV access is reflected appropriately in the clinical assessment. Facility Systems The facility will evaluate residents current smoking status upon admit during clinical IDT meeting. The ED or designee will complete education to staff in reporting to ED or DNS when a resident request to start smoking. The education will include completing a smoking evaluation for safety. The ED or DNS or designee will educate new residents, and their families upon smoking status and what the correct steps to take if they change their smoking status during their stay at the facility. DNS or designee will review the resident's desire to smoke weekly x 4 and make changes to the assessment as needed. In the clinical meeting the ID team will review new admits clinical records to ensure if they have an IV access the clinical assessment documentation is accuracy. SDC or designee will educate LN staff in completing the clinical assessment and the types of IV access devices. Monitor During the clinical meeting with IDT any new admissions will be reviewed for their current status of smoking. If the resident has a history of smoking he/ she will be monitor one time a week for four weeks to ensure no change.		

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F 272	<p>Continued From page 14</p> <p>smoking area without a smoking apron or smoking gloves on. Resident #6 was observed to light, hold, smoke, and extinguish his cigarettes without incident.</p> <p>On 9/20/16 at 4:20 pm, Resident #6 said he started smoking again within a few days after being admitted to the facility. He said he did not need staff assistance or a smoking apron.</p> <p>On 9/21/16 at 8:33 am, CNA #1 said Resident #6 had been smoking independently since he was admitted to the facility.</p> <p>On 9/21/16 at 8:55 am, LN #2 said she had observed Resident #6 and he smoked independently.</p> <p>On 9/21/16 at 1:25 pm, the DNS said the 8/10/16 smoking evaluation for Resident #6 did not reflect his current independence with smoking and a new evaluation had been completed that day [9/21/16].</p> <p>2. Resident #10 was admitted to the facility on 9/9/16, with diagnoses of cancer to the cervix, diabetes mellitus, and anxiety. Resident #10 entered the facility on hospice.</p> <p>Resident #10's clinical record documented the resident had a port-a-cath (a device implanted under the skin for intravenous - IV access) where Resident #10 had received chemotherapy. Resident #10's clinical record documented hospice staff were to flush the site.</p> <p>On Resident #10's Patient Nursing Evaluation, dated 9/12/16, "no" was marked for "IV or IV Access [sic]."</p>	F 272	<p>When a new resident is admitted into the facility the ID team during clinical meeting will review chart for accuracy on documentation if the resident has IV access or port-a-cath.</p> <p>PI monitor beginning with October PI meeting monthly x 3 months and then quarterly by DNS or designee</p>		

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F 272	Continued From page 15	F 272			
F 280 SS=D	<p>During an interview on 9/21/16 at 3:40 pm, LN #1 said she had misread the question on the nursing evaluation and marked "no." LN #1 indicated she was thinking of a "peripheral line."</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure 3 of 15 sampled residents' (#1, #4 and #6) care plans were revised and updated to reflect medication, smoking, and code status changes. This had the potential for more than minimal harm if residents</p>	F 280	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Transitional Care and Rehabilitation does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>F280</p> <p>Resident Specific</p>	10/27-16	

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F 280	<p>Continued From page 16</p> <p>did not receive appropriate care, or residents' code status wishes were not followed, due to lack of direction in their care plans. Findings include:</p> <p>1. Resident #1's diagnoses included anxiety disorder, femur fracture, and type 2 diabetes mellitus.</p> <p>A physician's order, dated 8/26/16, documented, "1. Continue 75 mg Sertraline (antidepressant) until 8/30, then D/C and start 2. Sertraline 50 mg PO for 7 days (9/6) then D/C and start 3. Sertraline 25 mg PO q HS for 7 days (9/13) then D/C Sertraline indefinitely."</p> <p>Resident #1's care plan, dated 7/11/16, with a target date of 10/9/16, documented Resident #1 was receiving an antidepressant medication for depression.</p> <p>Resident #1's September 2016 MAR lacked documentation of the resident received an antidepressant after 9/13/16.</p> <p>During an interview on 9/20/16 at 3:58 pm, the MDS Coordinator stated the nurses on the floor should have discontinued the care plan when the medication was discontinued.</p> <p>2. Resident #4's was admitted on 6/10/15, with diagnoses which included Multiple Sclerosis, CVA and hypertension.</p> <p>Resident #4's Physician Orders for Scope of Treatment (POST), dated 8/3/15, stated Resident #4's code status was "do not resuscitate".</p> <p>Resident #4's care plan, dated 6/10/15, and revised on 10/13/15, documented Resident #4</p>	F 280	<p>Resident's 1,4, and 6 were reviewed to ensure care plans are updated and reflect appropriate information. Resident 6 is no longer an active resident in this facility.</p> <p>Other Residents</p> <p>This facility will review each resident care plan for appropriate supporting documentation for anti-depressants and discontinue plans of care where appropriate. The facility will review care plans for appropriate reflection of code status on care plans. We will review assessments for any resident who has a history of smoking in the last year and verify supporting care plan documentation is valid.</p> <p>Facility Systems</p> <p>ED or designee will educate staff in resolving the care plans for residents with discontinued anti-depressants. Updating the care plans for residents who smoke and update the code status as needed. The facility will complete care plan reviews for smoking on admission, quarterly, and as needed.</p> <p>The facility will complete care plan reviews for code status on admission, quarterly, and as needed.</p> <p>The facility will review care plans for anti depressants on admission, quarterly, and as needed.</p>	

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F 280	<p>Continued From page 17 was a full code.</p> <p>During an interview on 9/20/16 at 11:15 am, the DNS stated Resident #4 had been a full code upon admission and the resident's code status was changed on 8/3/15. The DNS stated the care plan was incorrect. The DNS said nurses were trained to look at the POST to determine code status.</p> <p>3. Resident #6 was admitted to the facility on 8/9/16 with multiple diagnoses, including Parkinson's disease and weakness.</p> <p>On 9/20/16 at 9:30 am and 4:03 pm, Resident #6 was observed smoking in the designated smoking area.</p> <p>On 9/20/16 at 4:20 pm, Resident #6 said he started smoking again within a few days after being admitted to the facility.</p> <p>Resident #6's care plan did not include documentation that he smoked or interventions regarding smoking.</p> <p>On 9/21/16 at 8:33 am, CNA #1 said Resident #6 had been smoking independently since he was admitted to the facility.</p> <p>On 9/21/16 at 8:55 am, LN #2 said she had observed Resident #6 and he smoked independently.</p> <p>On 9/21/16 at 1:25 pm, the DNS said Resident #6's care plan did not indicate the resident smoked.</p>	F 280	<p>Monitors: The ID team during clinical meetings will review new orders and update care plans as needed. Any POST that goes out for MD signature, a copy will be given to the Director of Nursing to ensure care plan is updated correctly.</p> <p>PI monitor beginning with October PI meeting and monthly x 3 months and then quarterly by DS or designee</p>		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001370	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/22/2016
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the State licensure and complaint survey conducted at the facility from September 19, 2016 to September 22, 2016. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Shella Sizemore, RN Marcia Mital, RN	C 000	We are again requesting A waiver for bathing facilities.	10/27-16
C 422	02.120.05, p.vii Capacity Requirements for Toilets/Bath Areas vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water. This Rule is not met as evidenced by: Based on observation, Resident Group interview, and staff interview, it was determined the facility failed to ensure each resident floor or nursing unit was equipped with at least one tub or shower for every twelve licensed beds. This resulted in the facility lacking the number of required tubs or showers and created the potential to effect all residents in the facility. Findings include: The facility was licensed for 98 beds. On 9/21/16 at 10:30 am, the residents in the	C 422		

Bureau of Facility Standards

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

Debbie [Signature]

TITLE

Executive Director 10/14/16

(X6) DATE

STATE FORM

6899

YUR611

If continuation sheet 1 of 2

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001370	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/22/2016
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB .		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 422	Continued From page 1 Group interview said they did not have a problem with receiving baths or showers. On 9/22/16 at 9:35 am, during the environmental tour with the Maintenance Director, 6 bathing areas were observed, which included one bathing area in the therapy area. On 9/22/16 at 9:50 am, the Administrator confirmed there were only 6 bathing areas and 2 portable tubs in the facility and she requested to continue the waiver for the bathing areas.	C 422		



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
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March 17, 2017

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

Provider #: 135021

Dear Ms. Freeze:

On **September 22, 2016**, an unannounced on-site complaint survey was conducted at Kindred Transitional Care & Rehab - Lewiston. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted September 19, 2016 through September 22, 2016.

Staff interactions with residents and family members were observed throughout the survey.

The clinical record of the identified resident and 12 other residents' records were reviewed for Quality of Care and Resident Rights concerns. The facility's Grievance file and Resident Council meeting minutes from June 2015 through September 2016 and the facility's Resident Rights Admission paperwork was reviewed.

The identified resident and the resident's interested party were interviewed. Three other residents and one of the resident's interested party were interviewed. Several residents in the Group meeting were interviewed. The Director of Nursing Services was interviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007118

ALLEGATION #1:

The Reporting Party said an identified resident's rights were not respected by the facility when staff tried to treat the resident for pneumonia he/she did not have by insisting the resident receive a blood transfusion.

FINDINGS:

Observations conducted throughout the survey did not identify concerns with residents' rights regarding staff forcing medical decisions upon residents.

The identified resident's clinical record documented he/she was satisfied with staff treatment and received appropriate interventions for his/her medical conditions that were identified. The identified resident and other residents' records also did not identify concerns with resident rights, nor did the facility's Grievance file, Resident Group minutes or Resident Admission paperwork.

The identified resident said he/she did not feel his/her rights were compromised and when he/she has declined medical interventions he/she felt staff respected his/her wishes. The identified resident's interested party said he/she did not have concerns over the rights of the resident. Three other residents and one of the residents' interested party did not have any concerns with resident rights. Several residents in the Group meeting said there were no concerns with resident rights. The Director of Nursing Services said staff respected the rights of residents and would not force residents into a medical procedure they did not want.

Based on observation, record review, and resident, family and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

An identified resident's interested party was denied visitation rights and escorted from the building.

FINDINGS #2:

Several interested parties, including the Reporting Party, were observed visiting with residents throughout the survey, without being told to leave.

Debbie Freeze, Administrator
March 17, 2017
Page 3 of 3

The facility's Grievance file, Resident Group minutes and Resident Admission paperwork did not document concerns with visitation rights. The identified resident and other residents' clinical records did not identify concerns with visitation rights.

The identified resident said he/she did not feel his/her visitation rights were compromised, nor did the Reporting Party. Three other residents and one of the resident's interested party did not have any concerns with visitation rights. Several residents in the Group meeting said there were no concerns with visitation rights. The Director of Nursing Services said visitors were welcome as long as they did not cause a threat to residents.

Based on observation, record review, and resident, family and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large, sweeping "S" and a distinct "D".

David Scott, R.N., Supervisor
Long Term Care

DS/lj



IDAHO DEPARTMENT OF
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March 17, 2017

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

Provider #: 135021

Dear Ms. Freeze:

On **September 22, 2016**, an unannounced on-site complaint survey was conducted at Kindred Transitional Care And Rehab-- Lewiston. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted September 19, 2016 through September 22, 2016.

Medication Pass was observed. Residents were observed for meal intake, over-medication and dehydration throughout the survey. Social Service staff were observed for interaction with residents.

The clinical record of the identified resident and 12 other residents' records were reviewed for Quality of Care and Quality of Life concerns. The facility's Incident and Accident and Abuse Investigations from March 2016 to September 2016, including one for the identified resident, were reviewed. The facility's Grievance file and Resident Council minutes from June 2015 to September 2016 were reviewed.

Four sampled residents and several residents in the Group meeting were interviewed. The identified resident's interested party was interviewed. Two other residents' interested parties were interviewed. Several staff members and the Director of Nursing Services were interviewed.

Debbie Freeze, Administrator
March 17, 2017
Page 2 of 5

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007269

ALLEGATION #1:

The Reporting Party said the facility provided conflicting information and there was a lack of a thorough investigation of an identified resident's leg fracture.

FINDINGS:

Based on record review, family and staff interview, it was determined the allegation was substantiated and the facility was cited at F225 and F226. Please refer to the federal 2567 report.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The identified resident's non-fractured leg required an x-ray and treatment, but this was not done.

FINDINGS :

The clinical record of the identified resident and 12 other residents' records were reviewed for delay in treatment and no concerns were identified.

Three other residents and two residents' interested parties said they had no concerns regarding delay in treatment. Several residents in the Group meeting said they were treated appropriately. The Director of Nursing Services said residents received proper care.

Based on record review, resident, family and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Residents were being over-medicated.

FINDINGS:

Medication Pass was observed throughout the survey and no concerns were identified. Thirteen residents were observed for over-medication and no concerns were identified.

Thirteen residents' clinical records were reviewed for medication and no concerns were identified. The facility's Grievance file and Resident Council meeting minutes from June 2015 through September 2016 were reviewed and no medication concerns were identified.

Four residents and two residents' interested parties said over-medication was not a concern. Several residents in the Group meeting did not identify over-medication as a concern. Several nurses said residents received the proper medication per physician orders.

Based on observation, record review, resident, family, and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Residents were not properly hydrated or fed.

FINDINGS:

Residents were observed throughout the survey for fluid and meal intake and no concerns were identified. Multiple snack and hydration passes were also observed and no concerns were identified.

Thirteen residents' clinical records were reviewed for hydration and meal intake and no concerns were identified. The facility's Grievance file and Resident Council meeting minutes from June 2015 through September 2016 did not document an issue with dehydration or meal intakes.

Four residents, several residents in the Group meeting and two residents' interested parties said there were no issues with dehydration or meal intakes. Several CNAs said they passed snacks and fluids three times a day and assisted residents with meals and fluids.

Based on observation, record review, and resident, family and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

Residents were given the wrong medication and scheduled medications were not given as ordered.

FINDINGS:

Medication Pass was observed and no concerns were identified.

Thirteen residents' clinical records were reviewed for missing scheduled medications and no concerns were identified. The facility's Grievance file and Resident Council meeting minutes from June 2015 through September 2016 did not document medication concerns.

Four residents, several residents in the Group meeting and two residents' interested parties were interviewed and no medication concerns were identified. Several nurses said they administered the correct medication at the appropriate times.

Based on observations, record review, and resident, family and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The Social Worker was not advocating for the residents' needs.

FINDINGS:

Social Service staff were observed interacting with residents throughout the survey and no concerns were identified.

Thirteen residents' clinical records were reviewed for social services advocacy and no concerns

Debbie Freeze, Administrator
March 17, 2017
Page 5 of 5

were identified. The facility's Grievance file and Resident Council meeting minutes from June 2015 through September 2016 did not document a concern regarding social services.

Four sampled residents, several residents in the Group meeting and two residents' interested parties said social services advocated and arranged services for the residents. Social service staff said they took care of residents' needs.

Based on observation, record review, and resident, family and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

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 style with a large initial "D" and a long horizontal stroke.

David Scott, R.N., Supervisor
Long Term Care

DS/lj