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HEALTH & WELFARE

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January 6, 2017

Mary Ruth Butler, Administrator
Kindred Nursing And Rehabilitation--Mountain Valley
601 West Cameron Avenue
Kellogg, ID 83837-2004

Provider #: 135065

Dear Ms. Butler:

On **October 12, 2016**, an unannounced on-site complaint survey was conducted at Kindred Nursing And Rehabilitation-Mountain Valley. The complaint was investigated during an on-site complaint survey at the facility from October 11, 2016 to October 12, 2016.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007380

ALLEGATION #1:

The Reporting Party stated an identified resident was forced by a nurse into bed which resulted in bruising and skin tears on the resident's wrists.

FINDINGS:

On October 11, 2016 at 7:00 pm, a certified nursing assistant was observed assisting the resident with incontinent care, changing into his/her night clothes, transferring, and assisting with bed mobility. During the observation the surveyor did not identify or observe concerns related to the care and services provided by the certified nursing assistant.

The certified nursing assistant, when asked what he/she would do if the resident became combative or resistive to cares, stated, "I would make sure the resident was safe and walk way. I would wait for five-to-ten minutes and then re-approach. If the resident was still combative or resistant I would ask another certified nursing aide to help the resident."

Eight nurses, eight certified nursing assistants, the identified resident, ten additional residents and four family members were interviewed. The Director of Nursing, Social Service Director, Administrator, an advocate from a state agency, and the identified resident's Power of Attorney and family member were interviewed.

The identified resident, when asked how he/she got the bruise and skin tear on his/her hand, stated, "I don't know what happened and I don't know why. I think that I was probably doing something that I shouldn't have."

The advocate was interviewed and stated he/she visited the facility after the incident occurred and felt the identified resident and all residents in the facility were safe and he/she did not have concerns related to abuse and/or neglect.

The resident's Power of Attorney was interviewed and stated he/she had no concerns regarding abuse and felt the facility had handled the incident appropriately.

Eight nurses and eight certified nursing assistants described specific training they received relating to appropriate interventions for interacting with confused, resistive, and/or combative residents.

The Director of Nursing stated additional education related to abuse and managing residents with challenging behaviors was provided at a mandatory staff meeting and one-to-one education was completed with the nurse and certified nursing assistant involved in the alleged incident.

The identified resident's record and three other residents' records were reviewed. The facility's grievance file, reportable file, and incident and accident reports were reviewed from May 2016 to October 11, 2016. Resident council minutes were reviewed from May 2016 to October 11, 2016.

An Incident and Accident Report related to the identified incident documented the identified resident began "flailing his/her arms in the air" when the certified nursing assistant and nurse were in mid-transfer of the resident. The resident's wrist came in contact with the nurse's watch band several times during the transfer, which caused bruising and skin tears to the resident's wrist. The report documented the nurse involved in the incident "immediately" notified the Administrator, Director of Nursing, the resident's Power of Attorney, and the physician immediately after the incident occurred.

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The resident's record documented the areas of bruising and skin tears had been measured, recorded and were monitored and tracked weekly until they resolved.

Interventions implemented after the incident included a physical therapy screen, a speech therapy screen, and a trial of geri-sleeves to protect the resident's fragile skin.

Behavior monitor sheets reviewed from August 2016 to October 2016 did not document the identified resident had exhibited any behaviors during those months.

Training records were reviewed and documented staff had completed recognized training on July 29, 2016, and had taken two quizzes related to abuse on August 22, 2016 and August 29, 2016. Module two of the training was scheduled for November 3, 2016 and the facility would complete a new module every month.

Based on observations, interviews, and record review it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The Reporting Party stated the facility did not change residents into their night clothes for bed and did not change their soiled incontinent briefs.

FINDINGS:

The survey team entered the facility at 6:45 pm and observed twenty-one residents in their night clothing and five residents in regular clothing per their preference.

Eight nurses and eight certified nursing assistants were interviewed. Ten residents and four family members were interviewed. The Director of Nursing, Social Service Director, Administrator, an advocate from a state agency, and the identified resident's Power of Attorney and family member were also interviewed.

The identified resident's record and three other residents' records were reviewed. The facility's grievance file, reportable file, and incident and accident reports were reviewed from May 2016 to October 11, 2016. Resident council minutes were reviewed from May 2016 to October 11, 2016.

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Based on observations; resident, family, and staff interview; and record review 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. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

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

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

DS/lj