IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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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November 10, 2016

Mark Dudley, Administrator
Kindred Nursing And Rehabilitation - Weiser
331 East Park Street,
Weiser, ID 83672-2053

Provider #: 135010

Dear Mr. Dudley:

On **October 21, 2016**, a survey was conducted at Kindred Nursing And Rehabilitation - Weiser 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 in your facility to be **ISOLATED** and to constitute immediate jeopardy to residents' health and safety. You were informed of the immediate jeopardy situation(s) verbally and in writing on **October 20, 2016**.

On **October 20, 2016**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, it was determined that the immediate jeopardy to the residents had been removed. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction.

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 **November 20, 2016**. Failure to submit an acceptable PoC by **November 20, 2016** , may result in the imposition of additional civil monetary penalties by **December 13, 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.

- 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*.

Based on the immediate jeopardy cited during this survey:

F0323 -- S/S: J -- 483.25(h) -- Free Of Accident Hazards/supervision/devices

This agency is required to notify Centers for Medicare & Medicaid Services (CMS) Regional Office of the results of this survey. We are recommending to the CMS Regional Office that the following remedy(ies) be imposed:

Civil money penalty

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 19, 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 and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

Your facility's noncompliance with the following:

F0323 -- S/S: J -- 483.25(h) -- Free Of Accident Hazards/supervision/devices

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

> The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:
>
> Residents **#4 and #6** as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

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, 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.

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 **November 20, 2016** . If your request for informal dispute resolution is received after **November 20, 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,

David Scott, RN, Supervisor
Long Term Care

DS/pmt
Enclosures

cc: Chairman, Board of Examiners - Nursing Home Administrators

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135010		**10/21/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION - WEISER	**331 EAST PARK STREET** **WEISER, ID 83672**

(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 Federal Recertification and Complaint survey was conducted at the facility from October 17, 2016 to October 21, 2016. Immediate Jeopardy was identified at: * 42 CFR 483.25(h) [F323] The immediate jeopardy was removed prior to the exit conference. The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Angelia Newsome, RN, LNHA Juanita Stemen, MSN, RN, LNFA Arnold Rosling, RN, QMRP Definitions Include: CNA - Certified Nursing Assistant FDA - Food and Drug Administration LN - Licensed Nurse ml - milliliter mg/dl - milligram per deciliter OT - Occupational Therapy RNC - Regional Nurse Consultant SDC - Staff Development Coordinator PT - Physical Therapy EMAR - Electronic Medication Administration Record	F 000		
F 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in	F 159		12/6/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/18/2016

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

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F 159	Continued From page 1 paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person,	F 159		

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F 159	Continued From page 2 the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and review of the Resident Trust Fund Account, it was determined the facility failed to ensure quarterly trust account statements were provided to residents and/or their responsible parties. This was true for the 13 of 13 residents who had trust accounts, including 3 of 3 residents who participated in the resident group interview and had trust accounts. This created the potential for harm if residents and/or their responsible parties were unable monitor their trust fund accounts. Findings include: The Resident Trust Fund Account, reviewed on 10/20/16 at 12:27 pm, did not include documented evidence quarterly account statements were provided to 13 residents and/or their responsible parties, to make them aware of the balances and transactions in their trust accounts. During a resident group interview conducted on 10/18/16 at 11:00 am, 3 residents who had trust accounts reported not receiving quarterly statements to inform them or their responsible parties of balances or transactions. During an interview with the Business Office Manager on 10/20/16 at 12:27 pm, she reported 13 residents authorized the facility to manage their trust accounts. She confirmed she did not provide quarterly statements to the residents or	F 159	F159 Facility Management of Personal Funds Resident Specific The Business Office Manager distributed monthly statements to the 13 of 13 residents identified that included account activity, balance, and transactions. Other Residents The interdisciplinary (ID) team audited current residents with trust accounts and monthly statements have been distributed. No other issues were identified. Facility Systems The Business Office Manager is educated to resident trust management. Re-education was provided by the Executive Director to include but not limited to, frequency of statement distribution and validation of Resident Family Statement distribution. The system is amended to include retention of copies of Resident Family Statements and/or resident signatures. Resident Council agenda will be adjusted to include validation of residents are in receipt of their monthly statements. Any infractions identified will be brought to Executive Director's attention and remedied	

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F 159	Continued From page 3 their responsible parties, and added she sent out a monthly billing statement. She further stated she had not thought of sending out quarterly trust account statements because a monthly bill was provided, although the billing statement did not include information about the trust account activity, balance or transactions.	F 159	immediately. Monitor The Executive Director and/or designee will audit Resident Trust month-end folder and Resident Council minutes monthly x 3 months. Starting the week of December 4, the review will be documented on the PI audit tool. Any concerns will be addressed immediately. Monitoring results will be presented by Executive Director or designee at Quality Assessment/Performance Improvement (QAPI) meeting. Monitoring results and system components will be reviewed by the QAPI team with subsequent plan of corrections implemented as deemed necessary. The QAPI team may adjust the frequency of the monitoring after 3 months, as it deems appropriate. Date of Compliance December 6, 2016	
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and review of facility policies, it was determined the facility failed ensure grievances regarding lost items were resolved. This was true for 3 of 18 sampled	F 166	F166 Right to Prompt Efforts to Resolve Grievances Resident Specific	12/6/16

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F 166	Continued From page 4 residents (#15, #16 and #18). This deficient practice placed residents at risk of psychosocial harm due to lack of control over their belongings and inability to resolve their concerns through established processes. Findings include: 1. During the resident group interview on 10/19/16 at 11:00 am, Resident #15 reported several months ago he sent 3 pairs of pajamas to the laundry to be washed and only the tops of the pajamas were returned to him. He informed nursing staff immediately when his bottoms were not returned and nothing had been done. During an interview with the Assistant Social Worker (ASW) on 10/20/16 at 11:30 am, she reported the missing items were just brought to her attention "yesterday" on 10/19/16, after the group meeting ended at 12 noon and since then she had already ordered replacements for 4 sets of flannel pajamas from a local clothing store. She further stated she had since then informed Resident #15 the pajamas had been ordered and were scheduled for delivery in 7 days. 2. Resident #16 reported in the resident group interview on 10/19/16 at 11 am, that he had diabetes and renal failure. He said he went to appointments at the dialysis clinic 3 times per week. Resident #16 reported he brought a blood sugar monitoring accu-check machine from home to the facility so he could check his blood sugar while away from the facility. Resident #16 reported the machine was kept in the nurse's medication cart and when needed he would request his machine. Approximately 2 weeks ago he requested his machine and the nurse informed him the machine was missing. He said	F 166	Resident #15 – pajamas were replaced. Resident #16 – Blood Glucose Accu-Check replaced. Resident #18 – pajama was replaced. Other Residents The ID team reviewed current residents to validate there are no other unresolved grievances regarding lost items. No additional concerns were identified. Facility Systems The Assistant Social Worker (ASW) was educated by the Executive Director to document lost items on a grievance/concern form for tracking through to resolution. Other staff was re-educated by Staff Development Coordinator (SDC) and/or Executive Director regarding the grievance/concern process, to include but not limited to, documentation of missing items, validating a resolution, and transfer of issues identified in resident council to a grievance/concern form. The system is amended to include an agenda item during resident council that addresses management of missing items. Monitor The Executive Director and/or designee will audit missing item forms weekly X 4 weeks, then monthly X2. Starting the week of December 4, the review will be documented on the PI audit tool. Any concerns will be addressed immediately. Monitoring results will be presented by Executive Director or designee at QAPI	

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F 166	Continued From page 5 he spoke with the supervisor immediately, however, no one to date had gotten back with him even though a concern/ grievance form was completed. During a subsequent interview with the ASW on 10/20/16 at 11:40 am, she reported she did not remember a concern/ grievance form, but "yesterday (10/19/16)" she placed a written request for the hospital next door to provide Resident #16 with a new machine. The ASW provided a form from the physician and the hospital next door approving the replacement of the blood sugar machine. 3. Resident #18 reported in the resident group interview on 10/19/16 at 11:20 am, she sent her pajama top and bottom down to the laundry to be washed, but they were never returned to her. She indicated she informed the ASW approximately 1 month ago but she had heard nothing on the status of her lost items. During an interview with the ASW on 10/20/16 at 11:30 am, she reported the missing items were just brought to her attention "yesterday" on 10/19/16, after the group meeting ended at 12 noon and she had since then already ordered a replacement of 1 set of cotton pajamas from a clothing store. She further stated she had since then informed Resident #18 the pajamas had been ordered and were scheduled for delivery in 7 days. During an interview with the ASW on 10/20/16 at 1:30 pm, she confirmed the resident concerns/ grievances must have gotten lost in the shuffle.	F 166	meeting. Monitoring results and system components will be reviewed by the QAPI team with subsequent plan of corrections implemented as deemed necessary. The QAPI team may adjust the frequency of the monitoring after 3 months, as it deems appropriate. Date of Compliance December 6, 2016	

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F 166	Continued From page 6 4. Following the resident group meeting conducted on 10/19/16 at 11:00 am, a review of the facility's policy titled Grievance Policy and Procedure was completed. The policy stated when a resident and/or family voiced a concern, staff or the complainant should document the concern on the form labeled Grievance/Concern Form and forward the form to the ASW. The facility's Grievance file and Resident Council meeting minutes for 2016 were reviewed. No grievances had been transferred to paper, although staff were informed of the residents' grievances.	F 166		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, review of facility policies, and record review it was determined the facility failed to ensure 1 of 2 (#19) random residents was assessed to safely self-administer medications. This deficient practice created the potential for medication errors and harm if Resident #19 did not take his medications timely. Findings include: Resident #19 was admitted to the facility with multiple diagnoses including low back pain, intervertbral disc disorder in the lumbar region, scoliosis, hypertension, myocardial infarction,	F 176	F176 Resident Specific The clinical management team assessed resident #19 for safety in self-medication administration, then the physician order was obtained to allow self-administration of medication as resident is deemed safe. Other Residents The clinical management team reviewed other residents that self-administer medications for assessment, safety, and	12/6/16

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F 176	Continued From page 7 and congestive heart failure. Physician orders, dated October 2016, included: * Aspirin 81 mg tablet once a day for the heart * Klor-Con Extended Release (ER) 20 meq by mouth every day as a supplement * Tizanidine HCl 2 mg once a day for pain * Torsemide 100 mg give half a tablet once a day for congestive heart failure Resident #19's physician orders for October 2016, did not include an order for him to self-administer the identified medications. The facility's Self-Administration of Medications policy documented, if the Interdisciplinary Team (IDT) and the attending physician determine the resident is safe to self-administer medications a physician order is obtained and should identify the medication(s), dose, and route for the identified medications. The licensed nurses are responsible for following-up with the resident to validate the resident has taken the medication and should be documented on the resident's medication administration record as self-reported by the resident. The licensed nurse should monitor the resident's accuracy and compliance of self-administration for a period of time by observation. On 10/18/16 at 10:15 am, LN #4 was observed to dispense the above medications into a medication cup and enter Resident #19's room. Resident #19 refused to take the medications and stated, "You know that I don't take my medications this early." He directed the nurse to place the dispensed medication in his lock box located in the closet. When the nurse asked him	F 176	physician orders. No additional adjustments were indicated. Facility Systems The current licensed staff is educated by SDC and /or Director of Nursing Services (DNS) to Patient Self-Administration of Medication process, to include but not limited to, assessments, physician orders, and use of lock boxes. The system is amended to include addition of education in new licensed staff orientation. Monitoring The SDC and/or designee will complete perform surveillance rounds twice weekly for 4 weeks to validate medications left at the bedside/in a lock box are managed as per policy, then weekly for 8 weeks. Starting the week of December 4, the review will be documented on the PI audit tool. Any concerns will be addressed immediately. Monitoring results will be presented by the DNS or designee at QAPI meeting. Monitoring results and system components will be reviewed by the QAPI team with subsequent plan of corrections implemented as deemed necessary. The QAPI team may adjust the frequency of the monitoring after 3 months, as it deems appropriate. Date of Compliance December 6, 2016	

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F 176	Continued From page 8 if he had the key for the box Resident #19 stated, "No it is in my sock drawer." LN #4 was observed to remove the key from the drawer, unlock the box, place the medication inside the box, lock the box, and return the key to the sock drawer. Resident #19 stated he would take them later. The Electronic Medication Administration Record (EMAR) for October 2016 did not include documentation that LN #4 followed up with Resident #19 to ensure he took the medication or that Resident #19 self-reported taking the medications. On 10/18/16 at 10:20 am, LN #4 stated Resident #19 was cognitively aware and he could identify each medication and the reason for taking them. LN #4 stated she locked Resident #19's medications in his box every day and he would take them during the day. LN #4 stated Resident #19 kept the key with him until he took all of his medications and then placed the key back in the drawer.	F 176		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, family member, and staff interviews, it was determined the facility failed to ensure that 1	F 242	F242 Resident Specific	12/6/16

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KINDRED NURSING AND REHABILITATION - WEISER	331 EAST PARK STREET WEISER, ID 83672

(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 242	Continued From page 9 of 18 sampled residents (Resident #4), choice of when to arise in the morning was respected. This placed Resident #4 at risk for a decline in his psychosocial well-being. Findings include: Resident #4 was admitted to the facility on 7/3/13. Resident #4's MDS assessment, dated 3/4/16, included diagnoses of cerebrovascular accident (CVA), depression, chronic obstructive pulmonary disease (COPD), dysphagia, and arthritis. The assessment further documented Resident #4 had functional impairment on both sides of his upper and lower limbs. This consequently caused him to depend on 2 staff for extensive assistance in all transfers. Resident #4's 10/1/16 active physician orders included a gastrostomy tube, through which he received his nourishment at least 4 times per day, and as needed between feedings for breakthrough hunger. On 10/18/16 at 9:30 am, Resident #4 was observed in bed. As he was lying in bed, with some assistance from Family Member #1, he frequently suctioned copious amounts of clear thick sputum. Resident #4 shared that he wanted to get up earlier in the day, when other residents who eat in the dining room were assisted up. He said when he sits up he has less phlegm, and therefore, less need for suctioning. Resident #4 said Family Member #1 comes early morning every day to help him shave and brush his teeth, before he has to go to speech therapy. Family Member #1, present for the interview, stated she offered to get Resident #4 ready to get up, if staff would assist with getting him out of bed earlier.	F 242	The clinical management team met with resident #4 and his wife, revising his rising schedule to meet his desires. His plan of care is updated. Other Residents The ID team interviewed other current residents to validate their right to make choices, with their rising schedule, have been honored. No adjustments were indicated. Facility Systems Staff is educated by the SDC, ASW, and/or DNS to ask questions through use of the MDS and during Abaqis review to validate that resident choices are identified. Re-education is provided to include but not limited to, identification of resident choice desires, plan to meet resident desires, and validation that adjustments are communicated and made throughout resident stay. The system is amended to include documentation of discussion, family meetings, and plan of care in the medical record progress notes. Monitor The ASW and/or designee will audit 2 residents weekly for 4 weeks, then 5 residents monthly for 2 months to validate that their rising schedule is accommodated. Starting the week of December 4, the review will be documented on the PI audit tool. Any concerns will be addressed immediately. Monitoring results will be presented by	

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F 242	Continued From page 10 On 10/18/16 at 4:50 pm, Resident #4 was observed slowly wheeling himself, independently, in his wheelchair. He stated at that time that he tried to do 3 laps around the inside of the facility as exercise. On 10/18/19 at 3:00 pm, the DON was asked if she was aware of Resident #4's desire to get up for breakfast when other residents get up. She said he used to get up earlier than his current rising, but staff was getting rushed trying to get him up. She said in the interest of safety, his transfer time was changed to after breakfast. The DON said a meeting was held with Resident #4 and Family Member #1, and both agreed to the change. The DON attempted to explain the census and staffing issues. She said she was afraid the staff would rush through Resident #4's transfer, placing him at risk for injury. When the DON was told Resident #4 continued to desire the previous early rise time, the DON said she would have to think about how that could happen. When asked what she would do if Resident #4 received oral nourishment, she had no answer.	F 242	the ASW or designee at QAPI meeting. Monitoring results and system components will be reviewed by the QAPI team with subsequent plan of corrections implemented as deemed necessary. The QAPI team may adjust the frequency of the monitoring after 3 months, as it deems appropriate. Date of Compliance December 6, 2016	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. 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	F 280		12/6/16

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F 280	Continued From page 11 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed ensure interventions on residents' care plans related to mobility/ transfer status were reviewed and revised to reflect their current status. This was true for 2 of 18 sampled residents (#4 and #6). This deficient practice placed residents at risk for injuries related to improper transfers. Findings include: 1. Resident #4 was admitted to the facility on 7/3/13, with diagnoses including cerebrovascular accident (CVA) and arthritis. The assessment further documented Resident #4 had functional impairment to both sides of his upper and lower limbs. According to Resident #4's quarterly MDS assessment, dated 8/29/16, he required extensive assistance of 2 staff for transfers and was totally dependent on 2 staff for bed mobility. The assessment further stated Resident #4 had impaired range of motion to all limbs.	F 280	F280 Resident The clinical management team has revised resident #4 and #6 plan of care to reflect current mobility/transfer status. Other Residents The clinical management team has reviewed current residents care plans to validate they reflect current mobility/transfer status. Adjustments were made as indicated. Facility Systems Current licensed staff is educated to care plan revision process on hire. Re-education was provided by the SDC and/or DNS to include but not limited to, validate resident care plans have current mobility/transfer status reflected on admission and with change of condition. Education is provided during new licensed staff orientation for ongoing	

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F 280	Continued From page 12 On 10/18/16 at 9:30 am, in Resident #4's room, he was observed during a transfer from his bed to the wheelchair. LN #1 and CNA #5 utilized a sit-to-stand device to perform the transfer. During preparation for the transfer the previously mentioned staff positioned Resident #4 in a seated position on the edge of the bed, while the bed was in a raised position. While they were working with the harness (harness is secured around the resident to assist in supporting the resident), they were discussing how they needed to apply the harness. Resident #4, who later said he was 6 feet and 1 inches tall, abruptly fell backward across the bed. Resident #4 yelled as he fell backward onto the bed. The staff returned him to sitting on the edge of the bed. They then assisted Resident #4 to grab the sit-to-stand handgrip, and applied the harness. After securing Resident #4, the staff engaged the lift and transported him to his wheelchair. During the transfer Resident #4 did not stand. He was transferred in a squat like position. Resident #4's care plan dated 5/21/16 and revised on 10/7/16, with a focus on "Impaired physical mobility related to CVA" included a goal that Resident #4 would "maintain independence in wheelchair locomotion." There was no mention of transferring him utilizing the sit-to-stand. The only mention of a sit-to-stand in Resident #4's care plan was related to his potential for skin impairment. The intervention documented the use of Geri-sleeves during the sit-to-stand transfers to protect his skin from "abrasions and lacerations." Resident #4 did not have Geri-sleeves on during the aforementioned observation of his transfer. The care plan was not revised to include current interventions.	F 280	compliance. The system is amended to include plan of care validation of mobility/transfer status during clinical meeting post admission and for residents with change of condition. Monitoring The DNS and/or designee will complete 2 resident care plan reviews for mobility/transfer status weekly x4 weeks, then 4 resident reviews monthly x2 months. Starting the week of December 4, the review will be documented on the PI audit tool. Any concerns will be addressed immediately. Monitoring results will be presented by the DNS or designee at QAPI meeting. Monitoring results and system components will be reviewed by the QAPI team with subsequent plan of corrections implemented as deemed necessary. The QAPI team may adjust the frequency of the monitoring after 3 months, as it deems appropriate. Date of Compliance December 6, 2016	

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F 280	Continued From page 13 2. Resident #6, according to her admission MDS dated 4/27/16, was admitted to the facility on 4/15/16 with diagnoses to include muscle weakness, chronic pain, and end stage renal disease. On 10/19/16 at 1:17 pm, in Resident #6's room, CNA #3 and CNA #4 were observed transferring Resident #6 to provide incontinence care. As Resident #6 was lifted from the wheelchair, her legs remained bent and she never stood or bore weight on her legs. Her bottom remained at the level of the chair or below as the 2 aides provided incontinence care. At one moment during the care, Resident #6 moaned out loud. CNA #4 told her they were almost done with the care and they were hurrying. As Resident #6 dangled from the sit-to-stand, her bottom was at or below the level of the wheelchair she had just been removed from. The harness was up around the upper chest area and her arms were extended up above her chest. After the care was completed, Resident #6 was assisted back to the wheelchair. Resident #6's care plan, dated 4/14/16 and revised on 9/26/16, that focused on "ADL (activities of daily living) Self Care Performance deficit r/t (related to) end stage renal failure with hemodialysis" included a goal to improve transfers. However, the care plan had not been revised to include use of the sit-to-stand device for transfers. On 10/20/16 around 8:30 am, the SDC provided updated care plans, with revision dates of 10/19/16, for Resident #4 related to his impaired	F 280		

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F 280	Continued From page 14 mobility, which now included an intervention for a mechanical lift Hoyer with sling until therapy recommended transfer changes, and for Resident #6 related to her need for the use of a Hoyer lift for transfers. An Occupational Therapy (OT) Treatment Note, dated 10/20/16, documented Resident 6's sit-to-stand mechanical transfer safety assessment had been performed. The note confirmed Resident #6 demonstrated a poor "performance with transfer secondary to decrease in range and strength during transfers."	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure a) staff followed policies and procedures for medication administration, The failure to provide services that met or exceeded professional standards, directly impacted 1 of 18 sampled residents (#15). These deficient practices created the potential for residents not receive the appropriate mediation or other residents to have access to unsecured medications. Findings include: During initial tour of the facility on 10/17/16 at 10:05 am, Resident #15 was observed sitting upright in a chair in his room. On the bedside table were 2 round pills in a small plastic	F 281	F281 Resident Specific Resident #15 was assessed and there is no adverse effect related to the timing of medication administration. The Licensed Nurse has been re-educated through performance improvement plan. Other Residents The DNS and/or designee made rounds post medication administration times and did not identify any medications left at bedside for residents without self-medication assessments.	12/6/16

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F 281	Continued From page 15 medication cup. Resident #15 made no attempt to take the medication. At 10:10 am, LN #1 entered Resident #15's room. During an interview with LN #1 at that time, she reported Resident #15 did not self-administer his medication and she left the medications at his bedside in error. LN #1 reported the 2 pills were TUMS and administered the 2 pills to Resident #15 at 10:13 am. Resident #15's physician orders, reviewed at 11:00 am on 10/17/16, included an order for him to be administered 2 TUMS tablets daily. The facility policy and procedure titled Medication Administration documented that during medication administration the licensed nurse was to remain at the bedside and observe the resident take the medication as prescribed. Leaving medications at the bedside was an infraction of facility standards of practice.	F 281	Facility Systems The current licensed staff is educated and skills checked on medication management upon hire and annually. Reeducation was provided by SDC and/or DNS to include but not limited to, observation of the resident consuming the medication prescribed by the physician. This system is amended to include periodic surveillance to monitor for medication at bedside and not ingested post medication pass administration. Monitoring The SDC and/or designee will complete surveillance rounds twice weekly for 4 weeks to validate that no medications are left at the bedside post medication administration by the licensed nurse without evidence of following the self-medication assessment system, then weekly for 8 weeks. Starting the week of December 4, the review will be documented on the PI audit tool. Any concerns will be addressed immediately. Monitoring results will be presented by the DNS or designee at QAPI meeting. Monitoring results and system components will be reviewed by the QAPI team with subsequent plan of corrections implemented as deemed necessary. The QAPI team may adjust the frequency of the monitoring after 3 months, as it deems appropriate. Date of Compliance December 6, 2016	
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		12/6/16

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F 309 SS=D	Continued From page 16 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review it was determined the facility failed to ensure a) a resident received rapid acting insulin at the correct time, and that the amount of insulin administered was based on accurate blood sugar levels and b) physician orders were followed for administration of insulin. This was true for 1 of 5 (Resident #2) residents observed during medication administration. This placed Resident #2 at risk of hyperglycemia when he was administered rapid acting insulin greater than one hour after the lunch meal. Findings include: Resident #2 was admitted to the facility with multiple diagnoses including diabetes mellitus with hyperglycemia. Resident #2's physician orders, dated 10/10/16, included Novolog solution 100 units/ml - Inject as per sliding scale subcutaneously before meals and at bedtime for diabetes mellitus. The sliding scale was as follows: 0-149 = 0 units 150-200 = 3 units	F 309	F309 Resident Specific Resident #2 was assessed and there is no adverse effect related to the timing of medication administration. The Licensed Nurse has been re-educated through a performance improvement plan and the physician has been updated. Other Resident The clinical management team audited current residents for insulin administration orders for timely administration. No other infractions were identified. Facility Systems The current licensed staff is educated on following physician orders. Re-education was provided by the SDC and/or DNS to include but not limited to, insulin properties and administration protocol. The system is amended to include periodic surveillance of insulin protocols implementation.	

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F 309	Continued From page 17 201-250 = 6 units 251-300 = 9 units 301-350 = 12 units 351-400 = 15 units 401-450 = 18 units For blood sugar greater than 450 give 21 units and notify the medical doctor. The FDA's specifications for use state Novolog subcutaneous injections should, "generally be given immediately (within 5-10 minutes) prior to the start of a meal." On 10/18/16 at 11:50 am, Resident #2's blood sugar reading was 219 mg/dl, indicating he should receive 6 units of Novolog per the sliding scale. LN #6 told Resident #2 she would administer his sliding scale insulin after lunch. On 10/18/16 at 1:00 pm, LN #6 was observed to administer 6 units of Novolog to Resident #2. LN #6 stated she routinely administered Resident #2's sliding scale insulin after meals. When asked if she checked Resident #2's blood sugar after lunch prior to administering the sliding scale insulin, LN #6 stated she did not and gave the sliding scale insulin based on what Resident #2's blood sugar was prior to lunch. LN #6 stated Resident #2's physician was not aware she had been holding the sliding scale insulin until after meals. LN #6 then reviewed the physician's order and stated the sliding scale insulin should have been given prior to the meal.	F 309	Monitoring The SDC, pharmacy consultant, and/or designee will complete surveillance rounds once weekly for 4 weeks to validate insulin is administered as physician has ordered, then twice monthly for 2 months. Starting the week of December 4, the review will be documented on the PI audit tool. Any concerns will be addressed immediately. Monitoring results will be presented by the DNS or designee at QAPI meeting. Monitoring results and system components will be reviewed by the QAPI team with subsequent plan of corrections implemented as deemed necessary. The QAPI team may adjust the frequency of the monitoring after 3 months, as it deems appropriate. Date of Compliance December 6, 2016	
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		12/6/16

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F 323	Continued From page 18 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of manufacturer's recommendations, and staff interviews, it was determined the facility failed to ensure 2 of 3 residents (#4 and #6) requiring the use of mechanical devices for assistance with transfers, were monitored and re-evaluated for the continued appropriateness and safety of the devices; and staff were trained how to use the devices. These failures placed the health and safety of Residents #4 and #6, who required the use of a sit-to-stand device for transfers, in immediate jeopardy of serious injury, harm, or death. Findings include: 1. Resident #4 was admitted to the facility on 7/3/13. Resident #4's MDS assessment, dated 3/4/16, included diagnoses of cerebrovascular accident (CVA) and arthritis. The assessment further noted Resident #4 had functional impairment to both sides of his upper and lower limbs. On 10/18/16 at 9:30 am, in Resident #4's room, he was observed during a transfer from his bed to the wheelchair. LN #1 and CNA #5 utilized a sit-to-stand device to perform the transfer. During preparation for the transfer the previously mentioned staff positioned Resident #4 in a seated position on the edge of the bed, while the	F 323	F323 Resident Specific Resident #4 was reassessed by therapy for transfer status, he remains appropriate for sit-to-stand lift. Resident care plan was updated. Resident #6 was reassessed by therapy for transfer status, status was changed to sling lift, and care plan was updated. Other Residents The clinical management team has reviewed residents mobility/transfer status and no other residents utilize the sit-to-stand lift. Plan of care has been updated as indicated. Facility Systems Nursing staff is educated to the use of mechanical devices. Re-education was provided by the Rehabilitation Program Director, SDC, and/or DNS to include but not limited to evaluation of patients to utilize the lift, technical use of the sit-to-stand lift, and monitoring for patient safety while using the lift. The system is amended to include: " The Rehabilitation Program Director	

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F 323	Continued From page 19 bed was in a raised position. While they were working with the harness (harness is secured around the resident to assist in supporting the resident), they were discussing how they needed to apply the harness. Resident #4, who later said he was 6 feet and 1 inches tall, abruptly fell backward across the bed. Resident #4 yelled as he fell backward onto the bed. The staff returned him to sitting on the edge of the bed. They then assisted Resident #4 to grab the sit-to-stand handgrip, and applied the harness. After securing Resident #4, the staff engaged the lift and transported him to his wheelchair. During the transfer Resident #4 did not stand. He was transferred in a squat like position. LN #1 was present during the above transfer of Resident #4 on 10/18/16 at 9:30 am, utilizing the sit-to-stand device. LN #1 did not provide guidance to the CNA related to supporting Resident #4 during the preparation for transfer, appropriate height of the bed, or the inappropriateness of Resident #4's transfer position on the lift. An incident investigation, dated 8/7/16, involving Resident #4, documented 2 aides (CNA #6 and CNA #7) were assisting Resident #4 to sit on the edge of the bed to attach the (sling) harness, when he fell backward on the bed. According to the report, Resident #4, at that time, complained of mild ache-like pain between his shoulder blades. The "PI (Performance Improvement) Recommendations" noted on the incident documented "no change to plan of care, CNA re-education." Resident #4's care plan, revised on 10/7/16,	F 323	to oversee the center lift transfer program. Therapy will evaluate and make recommendations for resident transfer if sit-to-stand lifts are to be utilized,. " SDC has been educated on the use of the sit-to-stand and will educate licensed nurses and direct care staff on appropriate lift techniques with return demonstration for competency. Education includes the process for determining when the lift/transfer should not be continued. " Unsafe mechanical lift observations will be reported to the licensed nurse for directions. Then subsequently referred to the physical therapist and/or designee for potential change in transfer status. Monitor SDC and/or designee will observe each resident with a sit-to-stand transfer weekly x4 weeks, then twice monthly for 2 months, then monthly for 6 months. Starting the week of October 22, the review will be documented on the PI audit tool. Any concerns will be addressed immediately. New staff return-demonstration for competency with the sit-to-stand lift will be reviewed during the orientation period to validate staff demonstrates safety. Monitoring results will be presented by the SDC or designee at QAPI meeting. Monitoring results and system components will be reviewed by the QAPI team with subsequent plan of corrections	

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F 323	Continued From page 20 included a focus on "Impaired physical mobility related to CVA." An accompanying goal was for Resident #4 to "maintain independence in wheelchair locomotion." There was no mention of transferring him utilizing the sit-to-stand. During an interview with the Physical Therapy Director, on 10/18/16 at 2:38 pm, the therapist said the sit-to-stand was still the appropriate method of transfer for Resident #4. She said after the staff told her about the transfer observed at 9:30 am earlier on the same day, she provided training on the correct way to transfer Resident #4. When the surveyor asked if she observed the staff perform the transfer prior to providing the training, she said she had not. The therapist was asked if she was aware of the resident's previous (8/7/16) accident resulting in the same outcome during a transfer. The therapist said she was not aware that this type of accident had occurred before with Resident #4. During an interview on 10/19/16 at 6:30 pm, the SDC stated the licensed nursing staff were not required to complete a competency evaluation for the use of the sit-to-stand mechanical lift. The SDC further shared the licensed nursing staff were responsible for signing off the CNAs for the use of the sit-to-stand. LNs having no evaluation of their own competency for the use of the sit-to-stand, were required to evaluate competency for the CNAs. 2. Resident #6 was admitted to the facility on 4/15/16 with diagnoses to include muscle weakness, chronic pain, and end stage renal disease.	F 323	implemented as deemed necessary. The QAPI team may adjust the frequency of the monitoring after 3 months, as it deems appropriate. Date of Compliance December 6, 2016	

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F 323	Continued From page 21 On 10/19/16 at 1:17 pm, in Resident #6's room, CNA #3 and CNA #4 were observed transferring Resident #6 to provide incontinence care. Prior to the transfer, Resident #6 was observed sitting in a wheelchair at bedside. The staff placed the sit-to-stand device in front of Resident #6 and proceeded to secure the harness. They instructed Resident #6 to hold onto the handgrips on the device. After securing Resident #6, the sit-to-stand was engaged to lift her from the wheelchair. As she was lifted from the wheelchair, her legs remained bent and she never stood or bore weight on her legs. Her bottom remained at the level of the chair or below as the 2 CNAs provided incontinence care. At one moment during the care, Resident #6 moaned out loud. CNA #4 told her they were almost done with the care and they were hurrying. As Resident #6 dangled from the sit-to-stand, her bottom was at or below the level of the wheelchair she had just been removed from. The harness was up around the upper chest area and her arms were extended up above her chest. After the care was completed, Resident #6 was assisted back to the wheelchair. Resident #6's care plan, dated 4/14/16 and revised on 9/26/16, included a focus on "ADL (activities of daily living) Self Care Performance deficit r/t (related to) end stage renal failure with hemodialysis." A related goal was to improve transfers. The care plan not include interventions related to the sit-to-stand device used for the transfer. On 10/19/16 at 6:30 pm, an interview was conducted with the Staff Development Coordinator (SDC). During the interview the SDC	F 323		

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F 323	Continued From page 22 was informed of the observations of Resident #4 and Resident #6's transfers with the sit-to-stand. The SDC stated the CNAs would be the first to notice a decline in residents' transfer status. She indicated an assessment to determine appropriateness of a transfer method or a change in that method, would depend on the CNAs or nurses noticing and reporting a decline. The SDC further stated if injuries were noted, part of the investigation would be a review of the transfer equipment. She was unaware of any consistent follow-up observations of the aides demonstrating competency of the mechanical devices, specifically the sit-to-stand, or to determine the continued appropriateness for the device for the residents. The manufacturer's handbook for the sit-to-stand, copyright 2014, stated the sit-to-stand device should only be used for "residents/patients who can support at least 20% of their body weight." The manual further instructed the facility to assure only trained personnel was permitted to operate the lift. The manual further noted "Untrained operators can cause injury or be injured." The manufacturer's instruction were not followed prior to 10/20/16. The SDC was not trained in the use of the device until 10/20/16 and competencies with return demonstrations were not completed for LNs or CNAs prior to 10/20/16. Removal of Immediate Jeopardy: The Administrator, DON, SDC, and Corporate Representative were informed of the Immediate Jeopardy on 10/20/16 at 12:23 pm. Subsequently, the facility responded by providing a performance improvement action plan for	F 323		

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F 323	Continued From page 23 removal of the Immediate Jeopardy situation. The plan included: * The Rehabilitation Program Director to oversee lift transfer program. Rehabilitation Program Director will train the SDC on the sit-to-stand transfer. * The SDC will complete training to 1 LN and 1 CNA with return demonstration with satisfactory outcome. The trained LN and CNA to assist in training other LN and CNA staff. Therapy to assist. Staff will be able to verbalize what to do if a patient (resident) is not able to complete a sit to stand transfer safely. * The SDC and RN Supervisors will train LNs and CNAs on sit-to-stand transfer prior to their next scheduled shift, utilizing the skills checklist. LNs and CNAs will complete a return demonstration and must complete all areas as satisfactory before competency is completed. Staff will be able to verbalize what to do if the patient (resident) is not able to complete a sit to stand transfer safely (10/20/16 start and will continue until all staff are trained). * Surveillance observations to occur during sit-to-stand transfer at least weekly for 4 months, bi-weekly for 2 month, monthly for 6 month by SDC or RN Supervisor. * Sit-to-stand competencies for CNAs and LNs will be completed on hire, annually, and as needed, by SDC or designee. * The Rehabilitation Program Director or therapy designee will assess the competencies of trainers annually. * Residents transferred using a sit-to-stand will be observed quarterly, and as needed with change of condition, by physical therapy and SDC or RN Supervisor.	F 323		

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F 323	Continued From page 24 * Training for new hires will utilize skills checklist and include return demonstration with satisfactory outcome from SDC or RN Supervisor. * Therapy will provide demonstration to new hires in general orientation and quarterly x2 during general staff meetings on how to complete a sit-to-stand transfer and what to do when a sit-to-stand transfer does not go well. * Unsafe sit-to-stand observations will be reported to the physical therapist and/or designee for immediate review and intervention. * Sit-to-stand competencies and surveillance outcomes will be reviewed at monthly performance improvement meetings for 6 months. Along with the action plan, the facility provided proof of competencies for all staff, and return demonstrations of competencies. The plan was reviewed, the evening shift was trained prior to working, and the night/day shifts were called in for training and told they would not be able to work until the training/competency was completed. The SDC was trained and completed return demonstration. Surveyors then observed her as she trained staff. The SDC was observed performing a sit-to-stand transfer with a CNA. All nursing staff were required to take a competency test prior to working their next shift. After everything was validated, the Administrator, DON, and Regional Nurse Consultant, were informed the Immediate Jeopardy was removed on 10/20/16 at 4:40 pm.	F 323		
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive	F 328		12/6/16

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F 328	Continued From page 25 proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation and resident, staff, and outside service provider interview, the facility failed to ensure the maintenance on the oxygen (O2) concentrators was current for 2 of 3 residents in the facility that were using oxygen (#1 and #14). The lack of maintenance placed residents at risk of injury and/or adverse health outcomes due to malfunctioning O2 concentrators. Findings include: 1. Resident #1 was admitted to the facility on 1/19/16, with diagnoses of mood disorder and anxiety. Resident #1 had a physician's order, dated 7/6/16, for oxygen at 2 liters per minute via nasal cannula. During an interview on 10/17/16 at 2:30 pm, Resident #1 showed the surveyor his oxygen concentrator. The back of the plastic case showed signs the machine had gotten hot and the plastic was partially melted. Observation of the filter in the machine showed there was	F 328	F328 Resident Specific As per the CMS-2567, resident #1 and 14 had their concentrator replaced with serviced concentrators. Concentrators #1, #2, #3, #4, and #5 were also removed from building and replaced with concentrators that had preventive maintenance program completed. Other Residents The ID team audited resident rooms and storage areas for location of concentrators. Oxygen concentrators were validated to have clean filters and current service dates. Expired concentrator have been removed and replaced by the vendor. Facility Systems The current nursing staff, maintenance director, and central supply is educated by the SDC and/or DNS on the	

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F 328	Continued From page 26 buildup of material. Resident #1 stated he had told staff about the problem and that he could not remember when the plastic case melted. The maintenance sticker on the front of the machine showed the last maintenance was 11/13/13 and was due again 11/13/14. There was a physician's order, dated 10/2/16, that documented: "Change oxygen tubing, humidification bottle, and clean filter every week." The Medication Administration Record (MAR) documented this was done on 10/2/16, but not completed the following two weeks on 10/9/16 or 10/16/16. The Administrator was informed on 10/17/16 at 4:00 pm, and removed the machine from Resident #1's room. 2. Resident #14 was admitted to the facility 5/15/15, with diagnoses of Chronic Obstructive Pulmonary Disease, heart failure and obstructive sleep apnea. Resident #14's physician's order, dated 5/18/15, documented, "Oxygen at 2 liters per minute via CPAP (Continuous Positive Airway Pressure) Humidification: Frequency: at night every night." A physician's order, dated 7/5/16, documented "O2 (oxygen) saturation as needed for shortness of breath, if less than 90% initiate Oxygen as needed at 2 liters per minute via nasal cannula." On 10/17/16 at 4:15 pm, Resident #14's O2 concentrator was examined. The filter was in need of cleaning and the last maintenance performed was 9/21/14, and noted maintenance	F 328	maintenance of oxygen concentrators to include but not limited to, weekly cleaning of filters, placement of concentrators away from walls and heat sources, and validation of unexpired preventive maintenance stickers. The system is amended to include an inventory list of concentrators with the preventive maintenance schedule and periodic surveillance of concentrators filters and preventive maintenance stickers. The inventory list of concentrators is maintained by the maintenance director and/or central supply and reviewed by the Executive Director to validate that the concentrators are serviced routinely. Monitor The Maintenance Director and/or designee will audit concentrators weekly for 4 weeks, then monthly for 2 months to validate preventative maintenance is achieved. Starting the week of December 4, the review will be documented on the PI audit tool. Any concerns will be addressed immediately. Monitoring results will be presented by the Maintenance Director or designee at QAPI meeting. Monitoring results and system components will be reviewed by the QAPI team with subsequent plan of corrections implemented as deemed necessary. The QAPI team may adjust the frequency of the monitoring after 3 months, as it deems appropriate. Date of Compliance December 6, 2016	

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F 328	Continued From page 27 was due to be performed on 9/21/15. Resident #14 stated, at that time, he used the machine every night with his CPAP machine and was not aware of the maintenance issue. The Administrator was notified of the maintenance issues on 10/17/16 at 4:00 pm. At 4:15 pm, the Administrator was observed removing concentrators from oxygen storage room. There were five machines that were removed. Each had different maintenance expiration dates as follows: * Concentrator #1 - Service date: 2/15/15, and service due: 2/15/16 * Concentrator #2 - Service date: 11/13/13, and due date: 11/13/14 * Concentrator #3 - Service date: 11/13/13, and due date: 11/13/14 * Concentrator #4 - Service date: 9/21/14, and due date: 9/21/15 * Concentrator #5 - Service date: 11/9/14, due date: 11/9/15 The Administrator was interviewed on 10/17/16 at 4:15 pm, and stated that the facility had a contract with an outside agency to service the machines. On 10/17/16 at 5:20 pm, the maintenance person from the outside agency was in the facility collecting the seven outdated concentrators and replacing them with serviceable ones. The outside agency's maintenance person was interviewed and stated he came to the facility on Mondays and Thursdays to service the liquid oxygen and replace tanks. He was not aware he was to look at, remove, and replace the concentrators for maintenance.	F 328		

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F 328	Continued From page 28 The Administrator, District Director of Clinical Services, and Staff Development Coordinator, were interviewed 10/18/16 at 3:00 pm about the failed maintenance on the concentrators and a maintenance schedule. The Administrator indicated there was not currently (10/18/16) a scheduled maintenance plan for the oxygen concentrators in place.	F 328		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations, review of the facility maintenance log, and staff interview, it was determined the facility failed to ensure resident care equipment was maintained and serviced for 1 of 18 sampled residents (Resident #4). This failure to monitor and maintain equipment allowed staff to continue to use pertinent care equipment for the critical management of a resident requiring frequent suctioning, and placed the resident at risk of aspiration if the machine malfunctioned. Findings include: 1. On 10/18/16 at 8:45 am, a suction machine in Resident #4's room was observed to have a canister attached with approximately 100 cc of clear sputum. The inspection safety test was documented as most recently completed on 2/5/15. The label indicated the next date for the machine to be evaluated was 2/2016. A second	F 456	F456 Resident Specific Resident #4 and the dining room suction machines have had preventive maintenance was completed. Also, the patient lift/scale in the bathing room has had the preventive maintenance completed. Other Residents The ID team reviewed facility equipment and completed and inventory list with current service dates. Additional equipment has been serviced as indicated. Facility Systems	12/6/16

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F 456	Continued From page 29 suction machine in the room contained an inspection safety test label that documented the last time the machine was evaluated was 2/15/15 and required another inspection to be completed in 2/2016. 2. During the Environmental Tour On 10/18/16 at 10:00 am, with the Maintenance Director, he confirmed not all equipment was checked routinely as required. The Maintenance Director could offer no explanation of the facility's failure to ensure the necessary inspections were completed. Review of the Maintenance Log at this time showed the following items were due for inspection in February 2016, but were not inspected: * Dining Room Suction Machine * Bath Patient lift/scale * 2 Patient Suction Machines	F 456	The Maintenance Director and/or central supply has been educated by the Executive Director on developing a preventive maintenance program for facility owned and third party equipment to include but not limited to, inspection safety test monitoring. The system is amended to include an inventory list of medical equipment to be maintained by the maintenance director and/or central supply. Monitor The Maintenance Director and/or designee will audit medical equipment weekly for 4 weeks, then monthly for two months. . Starting the week of December 4, the review will be documented on the PI audit tool. Any concerns will be addressed immediately. Monitoring results will be presented by the Maintenance Director or designee at QAPI meeting. Monitoring results and system components will be reviewed by the QAPI team with subsequent plan of corrections implemented as deemed necessary. The QAPI team may adjust the frequency of the monitoring after 3 months, as it deems appropriate. Date of Compliance December 6, 2016	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing	F 463		12/6/16

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F 463	Continued From page 30 facilities. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, it was determined the facility failed to ensure the resident call system was functional and equipped to receive resident Emergency calls from private bathrooms for 2 of 30 residents residing in the facility (#12 and #13). This created the potential for harm when residents were unable to summon staff assistance when needed. Findings include: Resident #12 who resided in room 204, and Resident #13 who resided in room 206, shared an adjoining bathroom. During environmental rounds with the Maintenance Director on 10/19/16 at 10:50 am, the emergency call bells for residents who resided in rooms 204 and 206 were tested for proper functioning. When the bathroom emergency call bell was pulled for testing, the Maintenance Director immediately reported "this call bell has not worked since 10/6/16. The Maintenance Director provided the following information: On the morning of 10/6/16, a CNA presented him with a detached pull cord from the emergency call bell that serviced rooms 204 and 206. It was observed that the call light was not illuminating at the nurses' station or over the door of either resident's room, even when the call bell was pulled manually. On 10/6/16, electric company representatives came to the facility to assess the problem. They were unable to fix the call bell. Cordless doorbells were placed in the residents'	F 463	F463 Resident Specific Resident #12 and #13 were moved from rooms adjacent to the bathroom with malfunctioning call system. The electrician successfully repaired the call light issue on October 24, 2016 and successfully resolved the issue. The Maintenance Director has been re-educated through a performance improvement plan regarding notification of the Executive Director when safety equipment is malfunctioning and timely follow-up. Other Residents The ID team tested facility call light system. No other malfunctions were identified. Facility Systems The Maintenance Director was educated by the Executive Director to validate resident call system is functional to include but not limited to, timely repair of resident call system when malfunctions occur, communication with the Executive Director, staff education as to alternate plans/relocation of residents for safety, and follow-up with vendors. The system is amended to include monitoring the use of TELS platform to track malfunctions and	

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F 463	Continued From page 31 bathroom for them to push when they needed assistance while in the bathroom. The doorbells sounded at the nurses' station through a cordless speaker. A TABS (trademark) Alarm was also placed for the 2 residents to use in the event they fell and could not reach the doorbell. Resident #12 resided in room 204. Her MDS assessement, dated 9/15/16, documented she had the ability to express her ideas and the ability to understand others. On 10/19/16 at 10:55 am, she was asked how she would call for help if she were in her bathroom and required assistance. She reported she was mostly independent but would use the call bell in the bathroom. Resident #12 reported she knew nothing of a door bell or that her call bell was non-functional. On 10/20/16 at 10:50 am, the doorbell in the bathroom of room 204/206 was pushed for testing in the presence of the Maintenance Director. During an interview with CNA #1, who was also in the room, CNA #1 reported "I do not know what that sound is. I think it means it is time to exercise the residents." The Maintenance Director confirmed facility staff had not received education or in-service regarding the broken emergency call bell in rooms 204 and 206, nor had they been educated on the placement of the doorbell, sound of the doorbell, or placement of the TABS alarm. The electric company's report, dated 10/6/16, included a notation indicating the system was old with replacement parts not normally available. On 10/20/16, at approximately noon, the Administrator presented a written document that	F 463	repair timeline. Monitor The Maintenance Supervisor and/or designee will audit resident call light system weekly for 4 weeks, then every other week for 8 weeks. Starting the week of December 4, the review will be documented on the TELS platform. Any concerns will be addressed immediately. Monitoring results will be presented by the Maintenance Director or designee at QAPI meeting. Monitoring results and system components will be reviewed by the QAPI team with subsequent plan of corrections implemented as deemed necessary. The QAPI team may adjust the frequency of the monitoring after 3 months, as it deems appropriate. Date of Compliance December 6, 2016	

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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 463	Continued From page 32 indicated a cordless doorbell was installed on the left side of the toilet with a speaker placed at the nurses' station to inform nursing staff that help was needed in the bathroom serving rooms 204 and 206, due to no visual cue at the nurses' station. On 10/20/16, at approximately noon, the Administrator reported staff would be educated, Resident #13 in room 206 was being discharged home, and Resident #12 in room 204 would be moved to a room with a functional call bell, and the electric company would make a return visit today (10/20/16) to make another attempt to fix the broken call bell.	F 463		
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident, and outside service provider interview, review of manufacturer's recommendations, and record review, the facility failed to ensure it was administered in such a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical well-being for 6 of 18 sampled residents (#1, #4, #6, #12, #13, and #14). The administration failed to ensure a) LNs and CNAs were competent for the safe transfer of residents with mechanical	F 490	F490 Resident Specific Refer to F323 Refer to F328 Refer to F456 Refer to F463 Other Residents Refer to F323 Refer to F328	12/6/16

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F 490	Continued From page 33 lifts, b) oxygen concentrator equipment was safe for resident use, and c) suction equipment, call lights, and mechanical lifts were inspected and maintained in manner that protected residents from harm. Findings include: 1. Refer to F323 (Immediate Jeopardy) as it relates to the failure of the facility to ensure residents requiring the use of mechanical sit-to-stand lifts for assistance with transfers, were monitored and re-evaluated for the continued appropriateness and safety of the devices; and that staff were trained how to use the devices. This deficient practice placed 2 residents at risk of serious harm, injury, or death. The Administrator was questioned on 10/20/16 at 11:00 am, about competency of the staff who used the sit-to-stand lifts on residents. He indicated competencies were to be reviewed annually by an outside agency who monitored the facility. The Administrator said the Staff Development Coordinator was to report to the QA (Quality Assurance Committee) on the progress of the competencies. The Administer confirmed he was not aware staff competency evaluations for the use of sit-to-stand lifts were not being completed. 2. Refer to F328 as it relates to the failure of facility administration to ensure the maintenance on the oxygen (O2) concentrators was current. The Administrator, District Director of Clinical Services, and Staff Development Coordinator were interviewed 10/18/16 at 3:00 pm, about the failed maintenance on the concentrators and a maintenance schedule. The Administrator	F 490	Refer to F456 Refer to F463 Facility Systems The Executive Director was educated by the Vice President of Operations and/or the District Director of Clinical Operations regarding managing facility resources effectively and efficiently to maintain the highest practical well-being of residents. This includes but is not limited to, staff competencies with sit-to-stand lifts; preventative maintenance of oxygen concentrators, suction machines, call lights and the bathing mechanical lift. The system is amended as noted in F323, F328, F456, F463, and F520. Monitor The Vice President of Operations and/or designee will audit the Executive Director's use of resources monthly for 3 months. Any concerns will be addressed immediately. Monitoring results will be presented at the QAPI meeting. Monitoring results and system components will be reviewed by the QAPI team with subsequent plan of corrections implemented as deemed necessary. The QAPI team may adjust the frequency of the monitoring after 3 months, as it deems appropriate. Date of Compliance December 6, 2016	

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F 490	Continued From page 34 indicated there was no scheduled maintenance plan for the oxygen concentrators in place. 3. Refer to F456 as it relates to the failure of the facility to ensure suctioning machines and resident lifts/scales were inspected within required time frames to avoid harm to residents due to their malfunction. During the Environmental Tour On 10/18/16 at 10:00 am, with the Maintenance Director, he confirmed not all equipment was checked routinely as required. The Maintenance Director could offer no explanation of the facility's failure to ensure the necessary inspections were completed. 4. Refer to F463 as it relates to the failure of the facility to ensure the resident call system was functional and equipped to receive resident Emergency calls from private bathrooms. Resident #12 who resided in room 204, and Resident #13 who resided in room 206, shared an adjoining bathroom. During environmental rounds with the Maintenance Director on 10/19/16 at 10:50 am, the emergency call bells for residents who resided in rooms 204 and 206 were tested for proper functioning. When the bathroom emergency call bell was pulled for testing, the Maintenance Director immediately reported "this call bell has not worked since 10/6/16.	F 490		
F 498 SS=F	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and	F 498		12/6/16

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F 498	Continued From page 35 techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on review of staff training records and staff interviews, it was determined the facility failed to ensure 17 of 17 CNAs (#1-#5 and #7-18) whose competency evaluations were reviewed, were verified as competent to appropriately and safely transfer residents using a sit-to-stand mechanical lift. This resulted in the unsafe transfer of 2 residents requiring the use of a sit-to-stand mechanical lift. Findings include: 1. CNA skills competencies were reviewed for CNAs #1-#5 and #7-18. None of the new hire core competencies or the annual competencies for these staff included a demonstration of competency with the sit-to-stand mechanical lift. During an interview with the SDC, on 10/19/16 at 6:30 pm, she stated newly hired CNAs received, as part of their orientation, training on the Hoyer lift and the sit-to-stand. She said the new employee was paired with a CNA mentor for orientation on the floor. The SDC said the new employee would perform a return demonstration with the mentor (using the mechanical lifts) and the mentor then notified the nurse if the new employee was competent or needed more training. The nurse then signed off the core clinical competency based on the verbal report from the mentor. The SDC said she only followed-up on training of the mechanical lifts if there were concerns.	F 498	F498 Staff Specific Clinical management has completed the skills checklist education for current licensed nurses and direct care staff. Other Staff Not applicable, staff identified above. Facility System See F323, note return demonstration is included in the amended process. Monitor See F323 Date of Compliance December 6, 2016	

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F 498	Continued From page 36 The SDC said nurses were not required to complete the training or competencies for the mechanical lifts. Nurses, whose competency with the sit-to-stand mechanical lift was not verified, were responsible for checking off the competency of CNAs. The SDC provided an in-service, dated 7/8/16, for the sit-to stand. The in-service was a table top in-service where staff read the information and signed that they read it. It did not include a return demonstration. 2. Refer to F323 (Immediate Jeopardy) as it relates to the failure of the facility to ensure residents requiring the use of mechanical sit-to-stand lifts for assistance with transfers, were monitored and re-evaluated for the continued appropriateness and safety of the devices; and staff were trained how to use the devices. This deficient practice placed the health and safety of Residents #4 and #6 in immediate jeopardy of serious harm, injury, or death.	F 498		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment	F 520		12/6/16

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F 520	Continued From page 37 and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, review of manufacturer's instructions, and record review, it was determined the facility failed to have a Quality Assurance and Assessment (QAA) program that identified resident safety issues requiring the development and implementation of appropriate plans of action to correct the issues. This deficient practice directly impacted 6 of 18 sampled residents (#1, #4, #6, #12, #13, and #14). These deficient practice placed residents at risk of harm due to unsafe mechanical lift transfers and ill-maintained oxygen concentrators, suction machines, call lights, and bath/scale lift. Findings include: 1. Staff were observed unsafely transferring Resident #4 and Resident #6 without following the manufacturer's instructions when using the sit-to-stand mechanical lift. a. Resident #4 was admitted to the facility on	F 520	F520 Resident Specific Safety issues have been resolved as noted in F323, F328, F456, and F463 Other Residents Safety issues have been resolved as noted in F323, F328, F456, and F463 Facility Systems The ID team to include the Executive Director has been educated to the QAPI process by the Vice President of Operations and/or the District Director of Clinical Operations to include but not limited to resident safety issues requiring development and implementation of appropriate plans of action to correct the issues. The system is amended by updating the calendar of review items, as	

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F 520	Continued From page 38 7/3/13. Resident #4's MDS assessment, dated 3/4/16, included diagnoses of cerebrovascular accident (CVA) and arthritis. The assessment further noted Resident #4 had functional impairment to both sides of his upper and lower limbs. On 10/18/16 at 9:30 am, in Resident #4's room, he was observed during a transfer from his bed to the wheelchair. LN #1 and CNA #5 utilized a sit-to-stand device to perform the transfer. During preparation for the transfer the previously mentioned staff positioned Resident #4 in a seated position on the edge of the bed, while the bed was in a raised position. While they were working with the harness (harness is secured around the resident to assist in supporting the resident), they were discussing how they needed to apply the harness. Resident #4, who later said he was 6 feet and 1 inches tall, abruptly fell backward across the bed. Resident #4 yelled as he fell backward onto the bed. The staff recovered him and returned him to sitting on the edge of the bed. They then assisted Resident #4 to grab the sit-to-stand handgrip, and applied the harness. After securing Resident #4, the staff engaged the lift and transported him to his wheelchair. During the transfer Resident #4 did not stand. He was transferred in a squat like position. An incident investigation, dated 8/7/16, involving Resident #4, documented 2 aides (CNA #6 and CNA #7) were assisting Resident #4 to sit on the edge of the bed to attach the (sling) harness, when he fell backward on the bed. According to the report, Resident #4, at that time, complained of mild ache-like pain between his shoulder	F 520	well as assisting the team to develop a process by which to validate effectiveness of system revisions. Monitor The Vice President of Operations and/or designee will audit QAPI meeting content and process monthly for 3 months. Any concerns will be addressed immediately. Monitoring results will be presented at the QAPI meeting. Monitoring results and system components will be reviewed by the QAPI team with subsequent plan of corrections implemented as deemed necessary. The QAPI team may adjust the frequency of the monitoring after 3 months, as it deems appropriate. Date of Compliance December 6, 2016	

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F 520	Continued From page 39 blades. The "PI (Performance Improvement) Recommendations" noted on the incident documented "no change to plan of care, CNA re-education." During an interview with the Physical Therapy Director, on 10/18/16 at 2:38 pm, the therapist said the sit-to-stand was still the appropriate method of transfer for Resident #4. She said after the staff told her about the transfer observed at 9:30 am earlier on the same day, she provided training on the correct way to transfer Resident #4. When the surveyor asked if she observed the staff perform the transfer prior to providing the training, she said she had not. The therapist was asked if she was aware of the resident's previous (8/7/16) accident resulting in the same outcome during a transfer. The therapist said she was not aware that this type of accident had occurred before with Resident #4. LN #1 was present during the above transfer of Resident #4 on 10/18/16 at 9:30 am, utilizing the sit-to-stand device. LN #1 did not provide guidance to the CNA related to supporting Resident #4 during the preparation for transfer, appropriate height of the bed, or the inappropriateness of Resident #4's transfer position on the lift. During an interview on 10/19/16 at 6:30 pm, the SDC stated the licensed nursing staff were not required to complete a competency evaluation for the use of the sit-to-stand mechanical lift. The SDC further shared the licensed nursing staff were responsible for signing off the CNAs for the use of the sit-to-stand.	F 520		

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F 520	Continued From page 40 b. Resident #6 was admitted to the facility on 4/15/16 with diagnoses to include muscle weakness, chronic pain, and end stage renal disease. On 10/19/16 at 1:17 pm, in Resident #6's room, CNA #3 and CNA #4 were observed transferring Resident #6 to provide incontinence care. Prior to the transfer, Resident #6 was observed sitting in a wheelchair at bedside. The staff placed the sit-to-stand device in front of Resident #6 and proceeded to secure the harness. They instructed Resident #6 to hold onto the handgrips on the device. After securing Resident #6, the sit-to-stand was engaged to lift her from the wheelchair. As she was lifted from the wheelchair, her legs remained bent and she never stood or bore weight on her legs. Her bottom remained at the level of the chair or below as the 2 CNAs provided incontinence care. At one moment during the care, Resident #6 moaned out loud. CNA #4 told her they were almost done with the care and they were hurrying. As Resident #6 dangled from the sit-to-stand, her bottom was at or below the level of the wheelchair she had just been removed from. The harness was up around the upper chest area and her arms were extended up above her chest. After the care was completed, Resident #6 was assisted back to the wheelchair. The manufacturer's handbook for the sit-to-stand, copyright 2014, stated the sit-to-stand device should only be used for "residents/patients who can support at least 20% of their body weight." The manual further instructed the facility to assure only trained personnel was permitted to operate the lift. The manual further noted	F 520		

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F 520	Continued From page 41 "Untrained operators can cause injury or be injured." The manufacturer's instruction were not followed prior to 10/20/16. The SDC was not trained in the use of the device until 10/20/16 and competencies with return demonstrations were not completed for CNAs, nor the LNs, prior to 10/20/16. 2. Untimely and unsafe maintenance issues were identified with oxygen concentrators. Through investigation it was determined that there was no plan for preventative maintenance or servicing of the oxygen concentrators for two residents (Resident #1 and Resident #14) in the sample that were using the oxygen concentrators. a. Resident #1 had a physician's order, dated 7/6/16, for oxygen at 2 liters per minute via nasal cannula. During an interview on 10/17/16 at 2:30 pm, Resident #1 showed the surveyor his oxygen concentrator. The back of the plastic case showed signs the machine had gotten hot and the plastic was partially melted. Observation of the filter in the machine showed there was buildup of material. Resident #1 stated he had told staff about the problem and that he could not remember when the plastic case melted. The maintenance sticker on the front of the machine showed the last maintenance was 11/13/13 and was due again 11/13/14. The Administrator was informed on 10/17/16 at 4:00 pm, and removed the machine from Resident #1's room. He confirmed he was previously unaware the machine was partially melted and overdue for routine maintenance.	F 520		

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F 520	Continued From page 42 b. Resident #14 was admitted to the facility 5/15/15 with diagnoses of Chronic Obstructive Pulmonary Disease, heart failure and obstructive sleep apnea. On 10/17/16 at 4:15 pm, Resident #14's O2 concentrator was examined. The filter was in need of cleaning and the last maintenance performed was 9/21/14, and noted maintenance was due to be performed on 9/21/15. Resident #14 stated, at that time, he used the machine every night with his CPAP machine and was not aware of the maintenance issue. The Administrator was notified of the maintenance issues on 10/17/16 at 4:00 pm. At 4:15 pm, the Administrator was observed removing concentrators from oxygen storage room. There were five machines that were removed. Each had different maintenance expiration dates as follows: * Concentrator #1 - Service date: 2/15/15, and service due: 2/15/16 * Concentrator #2 - Service date: 11/13/13, and due date: 11/13/14 * Concentrator #3 - Service date: 11/13/13, and due date: 11/13/14 * Concentrator #4 - Service date: 9/21/14, and due date: 9/21/15 * Concentrator #5 - Service date: 11/9/14, due date: 11/9/15 The Administrator was interviewed on 10/17/16 at 4:15 pm, and stated that the facility had a contract with an outside agency to service the machines. On 10/17/16 at 5:20 pm, the	F 520		

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F 520	Continued From page 43 maintenance person from the outside agency was in the facility collecting the seven outdated concentrators and replacing them with serviceable ones. The outside agency's maintenance person was interviewed and stated he came to the facility on Mondays and Thursdays to service the liquid oxygen and replace tanks. He was not aware he was to look at, remove, and replace the concentrators for maintenance. The Administrator, District Director of Clinical Services, and Staff Development Coordinator, were interviewed 10/18/16 at 3:00 pm about the failed maintenance on the concentrators and a maintenance schedule. The Administrator indicated there was not currently (10/18/16) a scheduled maintenance plan for the oxygen concentrators in place. 3. Resident #12 who resided in room 204, and Resident #13 who resided in room 206, shared an adjoining bathroom. During environmental rounds with the Maintenance Director on 10/19/16 at 10:50 am, the emergency call bells for residents who resided in rooms 204 and 206 were tested for proper functioning. When the bathroom emergency call bell was pulled for testing, the Maintenance Director immediately reported "this call bell has not worked since 10/6/16. The Maintenance Director provided the following information: On the morning of 10/6/16, a CNA presented him with a detached pull cord from the emergency call bell that serviced rooms 204 and 206. It was observed that the call light was not illuminating at the nurses' station or over the door of either	F 520		

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F 520	Continued From page 44 resident's room, even when the call bell was pulled manually. On 10/6/16, electric company representatives came to the facility to assess the problem. They were unable to fix the call bell. Cordless doorbells were placed in the residents' bathroom for them to push when they needed assistance while in the bathroom. The doorbells sounded at the nurses' station through a cordless speaker. A TABS (trademark) Alarm was also placed for the 2 residents to use in the event they fell and could not reach the doorbell. Resident #12 resided in room 204. Her MDS assessement, dated 9/15/16, documented she had the ability to express her ideas and the ability to understand others. On 10/19/16 at 10:55 am, she was asked how she would call for help if she were in her bathroom and required assistance. She reported she was mostly independent but would use the call bell in the bathroom. Resident #12 reported she knew nothing of a door bell or that her call bell was non-functional. On 10/20/16 at 10:50 am, the doorbell in the bathroom of room 204/206 was pushed for testing in the presence of the Maintenance Director. During an interview with CNA #1, who was also in the room, CNA #1 reported "I do not know what that sound is. I think it means it is time to exercise the residents." The Maintenance Director confirmed facility staff had not received education or in-service regarding the broken emergency call bell in rooms 204 and 206, nor had they been educated on the placement of the doorbell, sound of the doorbell, or placement of the TABS alarm. The electric company's report, dated 10/6/16,	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135010		10/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION - WEISER	331 EAST PARK STREET WEISER, ID 83672

(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 520	Continued From page 45 included a notation indicating the system was old with replacement parts not normally available. On 10/20/16, at approximately noon, the Administrator presented a written document that indicated a cordless doorbell was installed on the left side of the toilet with a speaker placed at the nurses' station to inform nursing staff that help was needed in the bathroom serving rooms 204 and 206, due to no visual cue at the nurses' station. On 10/20/16, at approximately noon, the Administrator reported staff would be educated, Resident #13 in room 206 was being discharged home, and Resident #12 in room 204 would be moved to a room with a functional call bell, and the electric company would make a return visit today (10/20/16) to make another attempt to fix the broken call bell. 4. On 10/18/16 at 8:45 am, a suction machine in Resident #4's room was observed to have a canister attached with approximately 100 cc of clear sputum. The inspection safety test was documented as most recently completed on 2/5/15. The label indicated the next date for the machine to be evaluated was 2/2016. A second suction machine in the room contained an inspection safety test label that documented the last time the machine was evaluated was 2/15/15 and required another inspection to be completed in 2/2016. During the Environmental Tour On 10/18/16 at 10:00 am, with the Maintenance Director, he confirmed not all equipment was checked routinely as required. The Maintenance Director	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135010		10/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION - WEISER	331 EAST PARK STREET WEISER, ID 83672

(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 520	Continued From page 46 could offer no explanation of the facility's failure to ensure the necessary inspections were completed. Review of the Maintenance Log at this time showed the following items were due for inspection in February 2016, but were not inspected: * Dining Room Suction Machine * Bath Patient lift/scale * 2 Patient Suction Machines 5. On 10/20/16 at 11:00 am, the Administrator stated there was an annual calendar provided from the corporate office that identified the QA activities to be completed each month. He indicated the facility also used survey deficiencies and the CMS Casper reports for potential QA issues to review. The Administrator said the QA program was doing some quality monitoring, but was unable to explain what that included. The Administrator was unable to explain how the facility's QA process identified issues in the facility that were not listed on the corporate calendar, Casper reports, or survey deficiencies. There was no evidence of the staff identifying and reporting issues to the QA committee for review. The Administrator was questioned about competency of the staff who used the sit-to-stand lifts on residents. He indicated competencies were to be reviewed annually by an outside agency who monitored the facility. The Administrator said the SDC was to report to the QA Committee on the progress of the competencies. The Administer was told the	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135010		10/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION - WEISER	331 EAST PARK STREET WEISER, ID 83672

(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 520	Continued From page 47 sit-to-stand competencies were not being reviewed, and he confirmed he was not previously aware they were not being done as expected in the facility policy. The Administrator confirmed there was no QA being done to ensure quality care was provided with transfers. The Administrator was asked about the lack of QA involvement by the Maintenance Director, given he was aware of so many safety concerns, and he was not able to explain why the Maintenance Director was not included in the QA process.	F 520		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	MDS001830		**10/21/2016**

NAME OF PROVIDER OR SUPPLIER

KINDRED NURSING AND REHABILITATION - W

STREET ADDRESS, CITY, STATE, ZIP CODE

331 EAST PARK STREET
WEISER, ID 83672

(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 October 17, 2016 to October 20, 2016. The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Angelia Newsome, RN, LNHA Juanita Stemen, MSN, RN, LNFA Arnold Rosling, RN, QMRP	C 000		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/18/16

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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E-mail: fsb@dhw.idaho.gov

March 17, 2017

Mark Dudley, Administrator
Kindred Nursing And Rehabilitation-- Weiser
331 East Park Street
Weiser, ID 83672-2053

Provider #: 135010

Dear Mr. Dudley:

On **October 21, 2016**, an unannounced on-site complaint survey was conducted at Kindred Nursing And Rehabilitation- Weiser. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007268

ALLEGATIONS #1:

The Reporting Party stated an identified resident had specified her code status as "Do Not Resuscitate," yet staff sent her to a hospital for care where she suffered for two days before expiring.

FINDINGS:

The allegation could not be substantiated due to insufficient evidence the facility acted inappropriately.

Four surveyors conducted an onsite survey investigation between October 17, 2016 and October 20, 2016. Observations were conducted throughout the facility. Interviews were conducted with ten of the facility's thirty residents, as well as with two family members, one outside contractor and eighteen staff members. Records and facility documentation were reviewed for eighteen residents in the survey sample.

On November 1, 2015, the resident's blood sugar was assessed at 34 mg/dl (normal 70-99 mg/dl). She was alert, able to communicate and transferred without difficulty. Thirty minutes later the resident's blood sugar was assessed at 106 mg/dl. At 11:40 pm, staff responding to a noise coming from the resident's room found the resident lying on the left side of her bed, on her left side, with her feet on the floor and her knees against the wall. The resident moaned, but did not respond when her name was called. The resident's blood sugar was 137 mg/dl and the physician was notified. The resident was sent to a local hospital emergency room and a family member notified.

At approximately 1 am, the resident arrived at the local emergency room with a low heart rate and was admitted to the hospital where she was placed on a morphine IV for comfort before expiring on November 2, 2015.

There was no evidence the resident received Cardiopulmonary Resuscitation (CPR) at the facility or hospital.

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,

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

DS/lj

IDAHO DEPARTMENT OF
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March 17, 2017

Mark Dudley, Administrator
Kindred Nursing And Rehabilitation-- Weiser
331 East Park Street
Weiser, ID 83672-2053

Provider #: 135010

Dear Mr. Dudley:

On **October 21, 2016**, an unannounced on-site complaint survey was conducted at Kindred Nursing And Rehabilitation-- Weiser. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint #ID00007322

ALLEGATION #1:

The Reporting Party stated there are not enough Certified Nurses' Assistants to care for residents.

FINDINGS:

The allegation could not be substantiated due to insufficient evidence that the facility acted inappropriately.

Four surveyors conducted an on-site investigation at the facility from October 17, 2016 through October 20, 20156 in conjunction with the annual recertification survey. Numerous staff, family members and residents were interviewed. Observations were conducted throughout the facility. Eighteen residents were reviewed in the sample.

The investigation revealed call lights were answered in a timely manner and there we no foul odors indicating assistance was not provided promptly. Residents were observed to be clean and appropriately groomed. Staffing ratios met or exceeded the state's required levels. The residents denied any staffing problems.

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,

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

DS/lj

IDAHO DEPARTMENT OF
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March 17, 2017

Mark Dudley, Administrator
Kindred Nursing And Rehabilitation-- Weiser
331 East Park Street
Weiser, ID 83672-2053

Provider #: 135010

Dear Mr. Dudley:

On **October 21, 2016**, an unannounced on-site complaint survey was conducted at Kindred Nursing And Rehabilitation - Weiser. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted on October 17, 2016 to October 20, 2016.

The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint #ID00007327

ALLEGATION #1:

- Part A: The Reporting Party stated an identified resident with a terminal illness was "bullied" into participating in therapy and did not have the right to refuse.

- Part B: The facility would not allow the Reporting Party to access and receive copies of the identified resident's medical record.

FINDINGS:

Part A:

The records of eight residents who had either received or were receiving specialized therapy services were reviewed; eight residents were observed participating with therapies; three therapy staff, three individual residents, two family members, several residents during the group interview, and several nursing staff were interviewed; Resident Council minutes and Grievances were reviewed from July 2016 to October 18, 2016; Incident and Accident Reports were reviewed from May 2016 to October 18, 2016, and the facility's admission pack and resident rights were reviewed.

The identified resident was no longer residing in the facility at the time the complaint was investigated.

Eight residents were observed by the survey team participating with therapies and no concerns were identified.

The identified resident's medical record and eight other residents' records did not document concerns related to therapy services. The identified resident's record documented the resident expressed his desire to participate with therapy services, but that he "ultimately decided that he was not quite ready to die and wanted to try some rehabilitation first."

Resident Council minutes and Grievances were reviewed for July 2016 to October 18, 2016 and Incident and Accident Reports reviewed for May 2016 to October 18, 2016 did not document concerns related to therapy services.

Three therapy staff were interviewed and stated a resident refusing therapy would be assessed to determine the reason for the refusal and then staff would re-approach the resident at a later time.

Three individual residents, two family members, and several residents during the group interview did not express concerns related to therapy services.

Part B:

Resident Rights provided to the identified resident upon admission documented, "The Resident or his legal representative has the right upon oral or written communication to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays). After receipt of his or her records for inspection, the resident may purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and two working days advance notice to the center."

The identified resident's record was reviewed and documented he/she had given the facility permission to share his/her "lab results" with the Reporting Party. The facility documented the Reporting Party would be permitted to view the lab results with a member of the facility present and if the Reporting Party wished to obtain copies of the lab results the identified resident or his/her legal representative must first request copies of those records.

Members of the administrative team were interviewed and stated the facility upon oral and/or written request would make photo copies at twenty cents per page and would give the copies directly to the resident and/or the resident's legal representative.

Three individual residents, two family members, and several residents during the group interview did not express concerns related to accessing medical records.

Resident Council minutes and Grievances were reviewed for July 2016 to October 18, 2016 and Incident and Accident Reports reviewed for May 2016 to October 18, 2016 did not document concerns related to residents and/or legal representatives accessing medical records.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The Reporting Party stated call lights were not answered in a timely manner, which resulted in bowel and bladder incontinence for the identified resident.

FINDINGS:

The identified resident's medical record did not document the resident verbalized concerns related to call lights not being answered in a "timely manner."

The facility's June 2016 through October 18, 2016 Grievance files and Resident Council minutes did not indicate call light times were an issue.

Call light response times were observed and monitored by the survey team from October 17, 2016 through October 21, 2016 at various times of the day. The survey team did not identify concerns related to staff response times.

Three individual residents, two family members, and residents during the group interview stated they occasionally had to wait up to fifteen minutes to have their call lights answered. The residents and family members identified the increased wait times occurred during shift change and/or after meals when residents wanted/needed help at the same time.

Based on observations, resident and family 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,

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

DS/lj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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March 17, 2017

Mark Dudley, Administrator
Kindred Nursing And Rehabilitation- Weiser
331 East Park Street
Weiser, ID 83672-2053

Provider #: 135010

Dear Mr. Dudley:

On **October 21, 2016**, an unannounced on-site complaint survey was conducted at Kindred Nursing And Rehabilitation - Weiser. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007375

ALLEGATION #1:

The Reporting Party stated an identified resident is not receiving adequate toileting care.

FINDINGS:

The allegation could not be substantiated due to insufficient evidence to establish that the facility acted inappropriately.

Four surveyors conducted an on-site survey investigation from October 17, 2016 through October 20, 2016. Observations were conducted throughout the facility and interviews were conducted with ten of 30 sampled residents, two family members and 18 staff members. Resident records for 18 residents were also reviewed as part of the survey.

The investigation revealed the identified resident was alert and oriented, remembered going to a hospital for an X-ray, and said staff were prompt in returning her to the facility. The identified resident stated she had not been left in urine-stained clothing or taken out of the facility wearing urine-saturated/stained clothing. Staff interviewed about the allegation stated they remembered taking the resident to the hospital X-ray wearing clean and appropriate clothing and being well-groomed. Upon her return from the hospital, the resident stated she remained free from odors, was well-groomed, and wearing clean clothing. The resident self-toileted, and was aware of the need to use the bathroom. There were no concerns regarding incontinence care for any of the sampled residents.

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,

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

DS/lj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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April 20, 2017

Mark Dudley, Administrator
Kindred Nursing And Rehabilitation - Weiser
331 East Park Street,
Weiser, ID 83672-2053

Provider #: 135010

Dear Mr. Dudley:

On **October 21, 2016**, an unannounced on-site complaint survey was conducted at Kindred Nursing and Rehabilitation-- Weiser. The allegation was investigated during an on-site survey from October 17, 2016 through October 20, 2016. Observations were conducted throughout the facility and interviews were conducted with ten of thirty residents resident in the facility, two family members, one outside contractor and eighteen staff members. Resident records and facility documentation were reviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007312

ALLEGATION #1:

An identified resident who experienced burning with urination, but tested negative for infection, was not taken to a follow-up appointment with the urologist.

Findings #1:

The investigation concluded the resident was consulting with a urologist for his urination problems, and had an urology appointment within the next several weeks to discuss insertion of a catheter to address large post-void residuals.

This allegation is not substantiated for lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #2:

On June 3, 2016, an identified resident requested, but was denied, a physician-ordered PRN (as needed) "stomach pill" that staff denied to provide. Staff stated the medication was not available due to a "mix up" with the pharmacy.

Findings #2:

The idenfiied resident did not have a physician's order for any PRN "stomach" medication (antiemetic, antacid, etc.) and there were no concerns related to pharmachy services or medication administration identified through staff and resident interview, observation, and record review.

This allegation could not be substantiated due to a lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #3:

The facility is short-staffed and call lights are not answered.

Findings #3:

The investigation determined facility staffing records were adequate to meet federal and state requirements, as well as the needs of residents. No issues of concern involving adequate staffing levels or staff response times to residents' call lights were discovered during the survey from October 17, 2016 through October 20, 2016.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #4:

The resident experienced several falls while at the facility.

Findings #4:

The investigation determined the resident experienced unavoidable falls while at the facility, with the last accident occurring on April 20, 2016. The resident was independent with transfers and Activities of Daily Living and did not require assistance from staff. There was no evidence the resident was overly-sedated.

This allegation could not be substantiated for lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #5:

The identified resident's friend, who visited daily, was informed s/he could not longer visit the resident.

Findings #5:

The identified resident stated s/he and her/his friend had a disagreement and the resident no longer wanted the friend to visit. Other visitors were allowed access to the resident during night shift and there were no limitations placed by staff on the resident's ability to visit with friends and/or family.

This allegation was not substantiated for lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #6:

Staff deliver and leave the identified resident's meals in his/her room while s/he is sleeping. By the time the resident wakes up the food is cold and unpalatable.

Findings #6:

The investigation determined the resident received only the evening meal in his room so s/he could watch the evening news while eating. The reisent stated s/he could not remember any instance of a meal being left in his/her room, where it then became too cold to eat. The identified resident stated facility staff warmed up food upon any resident's request and that s/he had no concerns regarding the facility's food preparation, delivery, presentation, or taste.

This allegation was not substantiated for lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #7:

Staff is improperly trained.

Findings #7:

The allegation that the facility failed to provide staff with adequate training was substantiated.

The facility was cited with deficient practice at F498. Please refer to Federal 2567 Report for specific findings and details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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,

DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/lj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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April 20, 2017

Mark Dudley, Administrator
Kindred Nursing And Rehabilitation-- Weiser
331 East Park Street
Weiser, ID 83672-2053

Provider #: 135010

Dear Mr. Dudley:

On **October 21, 2016**, an unannounced on-site complaint survey was conducted at Kindred Nursing And Rehabilitation-- Weiser. An onsite survey investigation from October 17, 2016 to October 20, 2016 included observations throughout the facility, interviews with ten of thirty residents then residing at the facility, two family members, one outside contractor, and eighteen staff members. Resident records and facility documentation were reviewed. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007345

Allegation #1:

The resident had a speech therapy evaluation and was placed on thickened liquids, but denied ice chips and regular water when s/he became thirsty.

Findings #1:

The allegation of the facility failing to allow the resident ice chips and water was substantiated.

The investigation determined the identified resident's speech therapy evaluation recommendation called for thickened liquids. When the resident complained about the thickened liquid restriction, the facility orchestrated a follow-up examination that determined the resident no longer required thickened liquids.

The complaint was filed before the follow-up assessment was completed, however there were no identified concerns regarding the provision of thin liquids to those residents with applicable restrictions throughout the investigation survey.

Although the allegation that the resident was not allowed to have ice and water was substantiated at the time the complaint was filed, the facility was not cited because the investigation did not substantiate current deficient practice.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

One of the allegations was substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

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

DS/lj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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PHONE: (208) 334-6626
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May 19, 2017

Mark Dudley, Administrator
Kindred Nursing And Rehabilitation-- Weiser
331 East Park Street
Weiser, ID 83672-2053

Provider #: 135010

Dear Mr. Dudley:

On **October 21, 2016**, an unannounced on-site complaint survey was conducted at Kindred Nursing And Rehabilitation-- Weiser. An on-site survey investigation from October 17, 2016 to October 20, 2016. Observations were conducted throughout the facility. Interviews were conducted with ten residents, two family members, one outside contractor and eighteen staff members. Resident records and facility documentation were reviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007316

ALLEGATION #1:

The facility failed to administer medications in a safe manner.

FINDINGS:

The investigation revealed an identified resident was able to take medications without difficulty. The resident stated he/she was not aware of any medication concerns. The resident had concerns with swallowing in the past, he/she said, but was not experiencing any difficulty at the time of survey. There were no concerns identified regarding medication administration with any of the sample residents. This allegation was not substantiated due lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Staff was disrespectful to an identified resident.

FINDINGS:

The investigation revealed the administrative staff and Certified Nursing Aides were willing to listen to residents and the identified resident did not express any concerns regarding staff being disrespectful toward him. The resident was happy with the facility's floor staff and the administrative staff. There were no identified concerns regarding disrespectful staff behavior with any of the sample residents.

This allegation could not be substantiated due to lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Facility staff did not respect an identified resident's privacy.

FINDINGS:

The investigation revealed resident privacy was respected and personal information was not discussed in open areas. There were no privacy concerns with any of the sample residents. This allegation could not be substantiated due to lack of evidence.

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,

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

DS/lj