



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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Boise, Idaho 83720-0009
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December 23, 2016

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

Provider #: 135010

Dear Mr. Dudley:

On **December 14, 2016**, we conducted an on-site revisit to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **December 6, 2016**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- 0176-Resident Self-Administer Drugs If Deemed Safe-483.10(n)**
- 0280-Right To Participate Planning Care-Revise Cp-483.20(d)(3), 483.10(k)(2)**
- 0309-Provide Care/services For Highest Well Being-483.25**
- 0332-Free Of Medication Error Rates Of 5% Or More-483.25(m)(1)**
- 0333-Residents Free Of Significant Med Errors-483.25(m)(2)**

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 **January 3, 2017**.

The components of a Plan of Correction, as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

As noted in the Bureau of Facility Standards' letter of **November 10, 2016**, following the survey of **October 21, 2016**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for a Civil Monetary Penalty, Denial of Payment for New Admissions and termination of the provider agreement on **April 21, 2017**, if substantial compliance is not achieved by that time.

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

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If you believe the deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by January 3, 2017. If your request for informal dispute resolution is received after January 3, 2017, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Nina Sanderson, LSW, Supervisor
Long Term Care

Mark Dudley, Administrator
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/14/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - WEISER			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) COMPLETION DATE	
{F 000}	INITIAL COMMENTS The following deficiencies were cited during a revisit survey conducted at the facility on December 13, 2016 and December 14, 2016. The surveyors conducting the survey were: Linda Kelly, RN, Team Coordinator Presie Billington, RN Abbreviations Include: BG = Blood glucose [blood sugar] CNA = Certified Nursing Assistant COPD = Chronic obstructive pulmonary disease DMII = Type II Diabetes Mellitus DNS = Director of Nursing Services ESRD = End stage renal disease IDT = InterDisciplinary Team LN = Licensed Nurse MAR = Medication Administration Record MD = Medical Doctor MDS = Minimum Data Set mg = milligrams ml = milliliters O2 = Oxygen PN = Progress Notes prn = As needed SQ = Subcutaneous TAR = Treatment Administration Record	{F 000}			
{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.	{F 176}		1/21/17	

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

TITLE

(X6) DATE

Electronically Signed

01/03/2017

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 176}	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure residents who self administered medications had been assessed by the IDT and determined to be safe to do so. This was true for 1 of 12 sampled residents (#14) and 1 random resident (#25) observed during medication pass observations. The failure created the potential for the residents to receive less than optimal benefit from their nebulized medications. Findings include:</p> <p>On 12/14/16 at 8:45 am, LN #1 was observed as she administered an inhaler medication and 6 oral medications to Resident #14. She then set-up the resident's budesonide inhalation suspension for administration via nebulizer, placed the nebulizer face mask on Resident #14's, turned on the nebulizer, said "I'll be back" and left the room.</p> <p>On 12/14/16 at 8:53 am, LN #1 was observed as she entered Resident #25's room and asked her if she was ready for her respiratory treatment to stop. Resident #25 nodded yes and the LN turned off a nebulizer machine by the bed then removed the nebulizer face mask from Resident #25's face. At that point, Resident #25 said she needed to use the restroom and LN #1 left the room to find another staff to assist her. LN#1 walked down the hall toward the business office, found a CNA to assist her, then LN #1 and the CNA returned to Resident #25's room and closed the door.</p>	{F 176}	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Health & Rehabilitation - Weiser does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>F176 Resident Self-Administer Drugs If Deemed Safe Resident Specific The clinical management team assessed resident #14 and 25 for safety in self-medication administration of nebulizers, the physician order was obtained to allow self-administration of medication as resident is deemed safe, and care plan updated as indicated.</p> <p>Other Residents The clinical management team reviewed other residents that self-administer nebulizers and/or other medications for assessment, safety, physician orders, and care plan updates. Adjustments were made as indicated.</p> <p>Facility Systems</p>		

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{F 176}	<p>Continued From page 2</p> <p>On 12/14/16 at 9:05 am, LN #1 was observed as she exited Resident #25's room and returned to Resident #14's room. The LN checked the medication in the nebulizer's reservoir and said there was some medication left. LN #1 instructed Resident #14 to "take deep breaths." Two minutes later, the LN stopped the nebulizer and removed the face mask from Resident #14's face.</p> <p>An assessment for medication self-administration was not found Resident #14's clinical record.</p> <p>An assessment for medication self-administration was not found Resident #25's clinical record.</p> <p>On 12/14/16 at 9:25 am, LN #1 said she had administered "DuoNeb" to Resident #25 via nebulizer that morning. When asked if Resident #14 and Resident #25 had been assessed to self administer their nebulizer medication, the LN said "probably not." LN #1 said, "That's why I go back and forth" to check on them. The LN said, however, that she was in Resident #14's room for more than 5 minutes when Resident #25's DuoNeb treatment was going and in Resident #25's room 5 to 10 minutes when Resident #14's budesonide nebulizer treatment was going.</p> <p>On 12/14/16 at 9:35 am, the DNS was asked to provide the physician's order, current MAR, and the assessment for medication self administration for Resident #14's budesonide and #25's DuoNeb.</p> <p>On 12/14/16 at 11:00 am, the DNS provided the requested clinical records for both residents and said she did not find an assessment for</p>	{F 176}	<p>Current licensed staff is educated by Staff Development Coordinator (SDC), Director of Nursing Services (DNS) and/ or designee to Patient Self-Administration of Medication process, to include but not limited to, residents left unattended with medication in a nebulizer. The system is amended to include addition of education in new licensed staff orientation and review of new nebulizer orders in clinical meeting for the self medication assessment process.</p> <p>Monitoring The SDC and/or designee will complete surveillance rounds twice weekly for 4 weeks to validate medications are administrated per policy, then weekly for 8 weeks. Starting the week of January 22, 2017, 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.</p> <p>Date of Compliance January 21, 2017</p>		

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{F 176}	Continued From page 3	{F 176}			
{F 280} SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure residents' care plans were revised/updated to reflect their current diabetic and respiratory status. The was true for 2 of 12 sample residents (#16 and #24). The failure created the potential for more than minimal harm if the residents did not receive appropriate care due to lack of care planning or incomplete care plans. Findings include:</p>	{F 280}		1/21/17	
			This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Health & Rehabilitation - Weiser does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to		

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{F 280}	<p>Continued From page 4</p> <p>1. Resident #16 was admitted to the facility in 2013 with multiple diagnoses including ESRD and DM II.</p> <p>On 12/13/16 at 11:40 am, LN #3 said Resident #16 had been diabetic a "long time" and he "sometimes" refused or requested less insulin than ordered. The LN said the resident managed his diabetes, including how much insulin he gets, and the physician was aware and "okay" with that.</p> <p>Resident #16's current care plan focus areas and associated interventions included:</p> <ul style="list-style-type: none"> * Hemodialysis related to ESRD - "DIABETIC: inspect feet daily..." and "Dialysis days: Monday, Wednesday and Friday," both of which were revised 6/10/16; and * Risk for nutritional decline related to diabetes - "Diet as ordered..." revised 8/17/16. <p>The care plan did not address or include other aspects of diabetes management.</p> <p>On 12/14/16 at 2:40 pm, the DNS said Resident #16 managed his diabetes himself. She said that before 12/13/16, however, she was not aware he had refused or requested less NovoLog than ordered. The DNS said Resident #16's care plan did not include diabetic management and his refusals and requests for lesser doses of NovoLog should be in the care plan.</p> <p>2. Resident #24 was admitted to the facility on 10/27/16, with multiple diagnoses including stroke, COPD and difficulty in swallowing.</p>	{F 280}	<p>challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>F280 Participate Planning Care-Revise CP Resident Specific The clinical management team has revised resident #16 plan of care to reflect individualized diabetes management.</p> <p>The clinical management team has revised resident #24 plan of care to reflect current oxygen therapy and suction needs.</p> <p>Other Residents The clinical management team has reviewed current resident care plans to validate they reflect current diabetes management, oxygen therapy, and suction needs. Adjustments were made as indicated.</p> <p>Facility Systems Current licensed staff is educated by SDC, DNS and/or designee on the care plan revision process to include but not limited to, treatment for diagnosis of diabetes, individualizing care, the process at day 21 for the MDS and care plan development, new orders of oxygen therapy and suction needs. The system is amended to include addition of plan of care validation for diagnosis, significant medication and treatment use during clinical meeting post admission, at day 21</p>		

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{F 280}	Continued From page 5 Resident #24's admitting MDS assessment, dated 11/2/16, documented he had shortness of breath and difficulty swallowing. The Respiratory section of the MDS was checked off for oxygen therapy and suctioning. On 12/13/16 at 1:20 pm, Resident #24 was observed asleep, equipped with oxygen at 2 liters via nasal cannula, and on the left side of his bed was a suction machine. Resident #24's current care plan did not include his use of oxygen therapy and his need for suctioning.	{F 280}	in the MDS process, residents with change of condition, and/or new orders. Monitoring The DNS and/or designee will complete 2 resident care plan reviews post new admission, at day 21 of the MDS process, and/or with orders changes weekly x4 weeks, then 4 resident reviews monthly x2 months. Starting the week of January 22, 2017, 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 January 21, 2017		
{F 309} SS=E	483.25 PROVIDE CARE/SERVICES FOR 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	{F 309}		1/21/17	

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{F 309}	<p>Continued From page 6</p> <p>by:</p> <p>Based on observation, resident and staff interviews, and record review, it was determined the facility failed to ensure residents' rapid acting NovoLog insulin was administered within 15 minutes before meals, or with meals per physician orders. This was true for 4 of 6 residents (#14, #16, #20 and #21) reviewed for diabetic management. The facility also failed to ensure sliding scale NovoLog insulin was held when Resident #16 said he would not eat a meal and the dose of NovoLog was not changed without a physician's order. The failure created the potential for more than minimal harm if residents experienced hypoglycemia when their NovoLog was administered 30 minutes or longer before meals and when Resident #16's dose of NovoLog was decreased without a physician's order and administered when he said he would not eat a meal. Findings included:</p> <p>The Novolog manufacturer's recommendations documented Novolog (Insulin Aspart) as a rapid acting insulin and an injection of Novolog should immediately be followed by a meal (within 5-10 minutes).</p> <p>1. Resident #16 was admitted to the facility in 2013 with multiple diagnoses including DMII and ESRD.</p> <p>On 12/13/16 at 11:30 am, LN #3 was observed as she checked Resident #16's BG level, which was 221. Resident #16 said his BG level was high because he had eaten biscuits and gravy for breakfast and that he may not eat anything for lunch. LN #3 told Resident #16 his sliding scale "called for 4 units" of NovoLog. He said he would</p>	{F 309}	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Health & Rehabilitation - Weiser does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>F309 Provide Care/Services for Highest Well Being Resident Specific Resident #14, #16, #20, and #21 were assessed and there is no adverse effect related to the timing of insulin administration. The Licensed nurse was educated in documentation of the correct time of insulin administration and the # of units provided on the MAR, not just the progress notes with timely physician update.</p> <p>Other Residents The clinical management team audited current residents for rapid-acting insulin administration. Adjustments have been made to the time of insulin administration.</p> <p>Facility Systems Consulting Pharmacy Licensed Nurse has audited current diabetes management</p>		

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{F 309}	<p>Continued From page 7</p> <p>take 2 units of insulin but not 4 units. Resident #16 also refused 2 oral medications and said he was "not going to eat" at lunch time. At 11:35 pm, LN #3 was observed as she administered NovoLog 2 units SQ into Resident #16's left abdomen.</p> <p>On 12/13/16 at 11:40 am, LN #3 said Resident #16 had been diabetic a "long time" and he "sometimes" refused or requested less insulin than ordered. LN #3 said Resident #16 managed his diabetes, including how much insulin he gets, and the physician was aware and "okay" with that. LN #3 did not respond to questions about the rapid acting insulin administration after Resident #16 said he was not going to eat lunch, but said she would write a progress note and notify the physician that day.</p> <p>On 12/13/16 at 12:20 pm, Resident #16 was observed in his room eating spaghetti with meat sauce. He said he had planned to not eat lunch then added, "But I never miss spaghetti."</p> <p>Resident #16's current care plan focus areas and associated interventions included:</p> <ul style="list-style-type: none"> * Hemodialysis related to ESRD - "DIABETIC: inspect feet daily..." and "Dialysis days: Monday, Wednesday and Friday," both of which were revised 6/10/16; and * Risk for nutritional decline related to diabetes - "Diet as ordered..." revised 8/17/16. <p>The care plan did not address or include other aspects of diabetes management.</p> <p>Resident #16's "Active Orders As Of: 12/14/16"</p>	{F 309}	<p>process and suggested system changes. Current licensed staff is educated by SDC, DNS and/or on diabetes management to include but not limited to, insulin properties and administration protocol, how to manage residents who state are not going to eat, documentation of the timing of insulin, following MD orders for providing before or with the meal after determination of food consumed, and see F280 for care plan. The system is amended to include addition of education as above for new licensed staff orientation, periodic surveillance of insulin protocols implementation, and process to manage timing related to meal service.</p> <p>Monitoring The SDC, pharmacy consultant, and/or designee will complete surveillance rounds twice weekly for 12 weeks to validate insulin is administered as physician has ordered and manufacture recommendations. Starting the week of January 22, 2017, 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.</p>		

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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 309}	<p>Continued From page 8 documentation included:</p> <p>* "NovoLog PenFill Solution Cartridge...(Insulin Aspart)...per sliding scale."</p> <p>0 - 69 = 0 units, refer to hypoglycemia policy 70 - 150 = 0 units 151 - 200 = 2 units 201 - 250 = 4 units 251 - 300 = 6 units 301 - 350 = 8 units 351+ = 10 units..."subcutaneously with meals every Sun, Tue, Thu, Sat..." ordered 8/3/16 and started 8/4/16.</p> <p>* The same NovoLog insulin sliding scale as above, except "subcutaneously with meals every Mon, Wed, Fri..." ordered and started 8/3/16.</p> <p>* "Resident is capable of making his/her own health decisions" ordered 8/3/16.</p> <p>The 12/13/16 at 7:31 pm, Progress Notes documented the physician was notified Resident #16, "...refused the full dose of sliding scale insulin ac [before] lunch. Requested 2 units instead of 4 units..." and "She [physician] is aware that resident would request smaller insulin dose depending on what he was planning on eating for the meal...order received...that resident may exercise right to refuse/or ask for less of his insulin/medication...Resident has been a diabetic for quite some time, and has exercised that right in the past...[physician's name] has been aware that resident was adjusting accordingly..."</p> <p>The 12/13/16 at 7:31 pm, Progress Note did not document the physician was notified that</p>	{F 309}	Date of Compliance January 21, 2017		

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{F 309}	<p>Continued From page 9</p> <p>NovoLog insulin, ordered with meals, was administered 25 minutes before the lunch meal which Resident #16 said he was not going to eat. In addition, the December 2016 MAR documented NovoLog 4 units, not 2 units, was administered at 12:00 pm on 12/13/16.</p> <p>A 12/13/16 "Comprehensive Physician's Order Sheet For: Telephone / Standing / Clarified Orders..." documented, "Patient may exercise right to refuse or ask for less of his insulin / medication" which was signed by the physician and "noted 2000 [8:00 pm] 12/13/16" by a facility nurse.</p> <p>On 12/14/16 at 2:40 pm, the DNS said Resident #16 managed his diabetes himself and the physician was aware and "okay" that he sometimes refused or requested less insulin than ordered. The DNS said the physician, "came in last night" and wrote an order that Resident #16 could exercise his right to refuse or request less insulin than ordered. Regarding the rapid acting insulin administered 25 minutes before a meal that Resident #16 said he was not going to eat, the DNS said "30 minutes before or after" the scheduled time was "okay." The DNS said the documentation of NovoLog 4 units on 12/13/16 at 12:00 pm on the MAR was "wrong" but the Progress Notes documented 2 units, not 4 units, were given.</p> <p>On 12/14/16 at 3:30 pm, the DNS said she did not find documentation before 12/13/16 that the physician was aware Resident #16 managed his diabetes and sometimes refused or requested lesser doses of insulin than ordered.</p>	{F 309}			

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{F 309}	<p>Continued From page 10</p> <p>2. Resident #14 was admitted to the facility in 2015, with multiple diagnoses including DMII, asthma, and COPD.</p> <p>On 12/13/16 at 11:10 am, LN #3 was observed as she administered NovoLog insulin 6 units SQ to Resident #14 per his sliding scale orders for a BG level of 248. When asked what time lunch was, the LN said "12 o'clock." LN #3 said she "usually" waits to give sliding scale insulin "30 minutes or less before a meal."</p> <p>On 12/14/16 at 2:40 pm, the DNS said NovoLog insulin should be administered 15 minutes or less before a meal.</p> <p>Resident #14's rapid acting NovoLog insulin was administered 50 minutes before the lunch meal on 12/13/16.</p> <p>3. Resident #21 was readmitted to the facility on 7/26/16 with multiple diagnoses including DMII.</p> <p>On 12/13/16 at 11:15 am, LN #3 said the lunch meal was at "12 o'clock" and she "usually" waited to give sliding scale insulin "30 minutes or less before a meal." At 11:20 am, LN #3 was observed as she administered NovoLog insulin 2 units SQ to Resident #21 per her sliding scale orders for a BG level of 151.</p> <p>Resident #21's rapid acting NovoLog insulin was administered 40 minutes before the lunch meal on 12/13/16.</p> <p>4. Resident #20 was admitted to the facility on 4/15/16, with multiple diagnoses including diabetes mellitus.</p>	{F 309}			

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{F 309}	<p>Continued From page 11</p> <p>Resident #20's December 2016 physician orders and MAR included an order for Novolog Flexpen solution 100 units/ml inject per sliding scale subcutaneously two times a day for diabetes. The Novolog dose was to be held if Resident #20 was unable to eat the corresponding meal. The sliding scale was as follows:</p> <p>0 - 69 = 0 units, refer to hypoglycemic policy 70 - 80 = 0 units 81 - 100 = 3 units 101 - 150 = 12 units 151 - 200 = 19 units 201 - 250 = 28 units 251 - 300 = 33 units 301 - 350 = 36 units 351 - 400 = 40 units 401+ = 35 units and notify MD if greater than sliding scale range.</p> <p>On 12/14/16 at 11:10 am, LN #1 checked the blood sugar level of Resident #20, and it was 234. LN #1 went back to the medication cart and checked how much Novolog Resident #20 was to receive. LN #1 was observed to prepare 28 units of Novolog, and at 11:17 am, LN #1 administered the Novolog to Resident #20.</p> <p>On 12/14/16 at 12:05 pm, Resident #20 was observed sitting at the table in the dining room, waiting for his food to be served. At 12:10 pm, the Activity Director said they were just starting to deliver the food trays.</p> <p>On 12/14/16 at 12:17 pm, LN #1 said Resident #20 always received his Novolog sliding scale before his meals, as ordered.</p>	{F 309}			

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{F 309}	Continued From page 12	{F 309}			
F 332 SS=E	<p>On 12/14/16 at 12:20 pm, Resident #20 was observed eating his meal, 53 minutes after he received his Novolog per sliding scale.</p> <p>On 12/14/16 at 2:16 pm, the DNS said, she believed Novolog should be given 15 minutes before meals.</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure a medication error rate less than 5 percent. This was true for 5 of 33 medications (15%) during medication pass observations which affected 4 of 12 sampled residents (#14, #16, #20 and #21). The failure created the potential for hypoglycemia when rapid acting insulin was administered too early before a meal and for oral Candida (thrush) to develop from lack of rinsing and spiting after inhalation of a corticosteroid medication. Findings include: The manufacturer's documented Novolog (Insulin Aspart) as a rapid acting insulin and that an injection of Novolog should immediately be followed by a meal within 5-10 minutes.</p> <p>On 12/14/16 at 11:10 am, the Administrator</p>	F 332	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Health & Rehabilitation - Weiser does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>F332 Free of Medication Error Rates of 5% or More Resident Specific Resident #14, #16, #20, and #21 was assessed and there is no adverse effect</p>	1/21/17	

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F 332	<p>Continued From page 13</p> <p>provided the facility's "Insulin Quick Reference," dated 2002, which documented Novolog insulin, "Should be given just prior to...eating."</p> <p>The Nursing 2017 Drug Handbook patient teaching regarding Novolog insulin documented, "...give insulin at appropriate time around a meal..."</p> <p>1. Resident #14 was readmitted to the facility in May 2015 with multiple diagnoses, including DMII, asthma and COPD.</p> <p>Resident #14's "Active Orders As Of: 12/14/16" included a 4/6/16 order for Novolog insulin per sliding scale SQ before meals and at bedtime and a 7/24/16 order for budesonide suspension inhaled twice a day.</p> <p>a. On 12/13/16 at 11:10 am, LN #3 was observed as she administered Resident #14's rapid acting Novolog insulin. At 11:15 am, the LN said lunch was scheduled for 12:00 pm and that she "usually" waits to give sliding scale insulin 30 minutes or less before meals.</p> <p>Resident #14's rapid acting insulin was administered 50 minutes before the meal.</p> <p>b. On 12/14/16 at 8:55 am, LN #1 was observed as administered an inhaler medication, 6 oral medications then budesonide (corticosteroid) inhalation suspension via nebulizer to Resident #14. After the budesonide nebulizer treatment, LN #1 did not encourage or instruct Resident #14 to rinse his mouth and spit or provide water for him to do so.</p>	F 332	<p>related to the timing of insulin administration. License nurse was educated to offer a rinse after the administration of budesonide (corticosteroid) for resident #14.</p> <p>Other Resident The clinical management team audited current residents for insulin administration orders timing and directives to rinse after corticosteroid inhalation.</p> <p>Facility Systems Current licensed staff is educated by SDC, DNS and/or on medication administration to include but not limited to, insulin properties and administration protocol, use of corticosteroid inhalation and potential for thrush. The consulting pharmacy Licensed Nurse has audited current diabetes management process and suggested system changes. The system is amended to include addition of education in new licensed staff orientation for what constitutes a medication error, periodic surveillance of medication administration (to include insulin and corticosteroid inhalation), see F280 and F309.</p> <p>Monitoring The SDC, pharmacy consultant, and/or designee will complete surveillance rounds twice weekly for 12 weeks to validate licensed nurses develop good habits and prevent medication errors during medication administration process. Starting the week of January 22, 2017,</p>		

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F 332	<p>Continued From page 14</p> <p>On 12/14/16 at 9:25 am, LN #1 said she did not have Resident #14 rinse his mouth and spit after the budesonide nebulizer treatment but she would go and do it right then.</p> <p>2. Resident #16 was admitted to the facility in 2013, with multiple diagnoses including DMII and ESRD.</p> <p>Resident #16's "Active Orders As Of: 12/14/16" included orders for NovoLog insulin per sliding scale SQ with meals every day, ordered 8/3/16.</p> <p>On 12/13/16 at 11:15 am, LN #3 said the lunch meal was scheduled for 12:00 pm and that she "usually" waits to give sliding scale insulin 30 minutes or less before meals.</p> <p>On 12/13/16 at 11:30 am, Resident #16 told LN #3 that he may not eat lunch. LN #3 told Resident #16 his sliding scale "called for 4 units" of NovoLog. Resident #16 said he would take 2 units of insulin but not 4 units. Resident #16 also refused 2 oral medications and said he was "not going to eat" at lunch time.</p> <p>On 12/13/16 at 11:35 pm, the LN was observed as she administered NovoLog 2 units SQ into Resident #16's left abdomen.</p> <p>Resident #16's rapid acting insulin was administered 25 minutes before the lunch meal which he said he was not going to eat and the dose was decreased without a physician's order.</p> <p>3. Resident #21 was readmitted to the facility in July 2016 with multiple diagnoses, including DMII.</p>	F 332	<p>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.</p> <p>Date of Compliance January 21, 2017</p>		

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F 332	<p>Continued From page 15</p> <p>Resident #21's "Active Orders As Of: 12/14/16" included Novolog insulin per sliding scale SQ before meals, dated 11/22/16.</p> <p>On 12/13/16 at 11:15 am, LN #3 said the lunch meal was scheduled for 12:00 pm and that she "usually" waits to give sliding scale insulin 30 minutes or less before meals.</p> <p>On 12/13/16 at 11:20 am, LN #3 was observed as she administered Resident #21's rapid acting Novolog insulin.</p> <p>Resident #21's rapid acting insulin was administered 40 minutes before the meal.</p> <p>On 12/14/16 at 2:40 pm, the DNS said NovoLog insulin should be administered 15 minutes or less before a meal.</p> <p>On 12/14/16 at 4:15 pm, the DNS said the facility references the Nursing 2017 Drug Handbook and their pharmacy regarding medications.</p> <p>4. Resident #20 was admitted to the facility on 4/15/16, with multiple diagnoses including diabetes mellitus.</p> <p>Resident #20's December 2016 physician orders and MAR included an order for Novolog Flexpen solution 100 units/ml inject per sliding scale subcutaneously two times a day for diabetes. The Novolog dose was to be held if Resident #20 was unable to eat the corresponding meal. The sliding scale was as follows:</p> <p>0 - 69 = 0 units, refer to hypoglycemic policy</p>	F 332			

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F 332	Continued From page 16 70 - 80 = 0 units 81 - 100 = 3 units 101 - 150 = 12 units 151 - 200 = 19 units 201 - 250 = 28 units 251 - 300 = 33 units 301 - 350 = 36 units 351 - 400 = 40 units 401+ - 35 units and notify MD if greater than sliding scale range. On 12/14/16 the following observations were made: *11:10 am, LN #1 checked Resident #20's blood sugar. It was 234. *11:17 am, LN #1 administered 28 units of Novolog insulin to Resident #20. *12:05 pm, Resident #20 was at a dining room table waiting for his meal to be served. *12:10 pm, the food trays were being delivered to residents in the dining room. *12:20 pm, Resident #20 was being assisted to eat. On 12/14/16 at 2:16 pm, the DNS said, she believed Novolog should be given 15 minutes before meals.	F 332			
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333		1/21/17	

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F 333	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility's Insulin Quick Reference, and resident and staff interview, it was determined the facility failed to ensure there were no significant medication errors for 4 of 12 sampled residents (#14, #16, #20 and #21) during medication pass observations. The failure created the potential for the residents to experience hypoglycemia when rapid acting insulin was administered too early before meals and after Resident #16 said he was not going to eat a meal. In addition, Resident #16's insulin dose was changed without a physician's order. Findings include:</p> <p>The manufacturer documented Novolog (Insulin Aspart) as a rapid acting insulin and that an injection of Novolog should immediately be followed by a meal within 5-10 minutes.</p> <p>On 12/14/16 at 11:10 am, the Administrator provided the facility's "Insulin Quick Reference," dated 2002, which documented Novolog insulin, "Should be given just prior to...eating."</p> <p>Regarding Novolog insulin, the Nursing 2017 Drug Handbook patient teaching documented, "...give insulin at appropriate time around a meal..."</p> <p>1. Resident #16 was admitted to the facility in 2013 with multiple diagnoses including DMII and ESRD.</p> <p>Resident #16's "Active Orders As Of: 12/14/16" included orders for NovoLog insulin per sliding</p>	F 333	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Health & Rehabilitation - Weiser does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>F333 Residents Free of Significant Med Errors Resident Specific Resident #14, #16, #20, and #21 was assessed and there is no adverse effect related to the timing of medication administration.</p> <p>Other Resident See F309 and F332</p> <p>Facility Systems See F309 and F332</p> <p>Monitoring See F309 and F332</p> <p>Date of Compliance January 21, 2017</p>		

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F 333	<p>Continued From page 18</p> <p>scale SQ "with meals" every day, dated 8/3/16.</p> <p>On 12/13/16 at 11:15 am, LN #3 said the lunch meal was scheduled for 12:00 pm and that she "usually" waits to give sliding scale insulin 30 minutes or less before meals.</p> <p>On 12/13/16 at 11:30 am, Resident #16 told LN #3 that he may not eat lunch. LN #3 told Resident #16 his sliding scale "called for 4 units" of NovoLog. Resident #16 said he would take 2 units of insulin but not 4 units. Resident #16 also refused 2 oral medications and said he was "not going to eat" at lunch time.</p> <p>On 12/13/16 at 11:35 pm, the LN was observed as she administered NovoLog 2 units SQ into Resident #16's left abdomen.</p> <p>Resident #16's rapid acting insulin was administered 25 minutes before the lunch meal which he said he was not going to eat and the dose was decreased without a physician's order.</p> <p>2. Resident #14 was readmitted to the facility in May 2015, with multiple diagnoses, including DMII, asthma, and COPD.</p> <p>Resident #14's "Active Orders As Of: 12/14/16" included a 4/6/16 order for Novolog insulin per sliding scale SQ before meals and at bedtime and a 7/24/16 order for budesonide suspension inhaled twice a day.</p> <p>On 12/13/16 at 11:10 am, LN #3 was observed as she administered Resident #14's rapid acting Novolog insulin. At 11:15 am, the LN said lunch was scheduled for 12:00 pm and that she</p>	F 333			

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F 333	<p>Continued From page 19</p> <p>"usually" waits to give sliding scale insulin 30 minutes or less before meals.</p> <p>Resident #14's rapid acting insulin was administered 50 minutes before the meal.</p> <p>3. Resident #21 was readmitted to the facility in July 2016 with multiple diagnoses, including Dm II.</p> <p>Resident #21's "Active Orders As Of: 121416" included Novolog insulin per sliding scale SQ before meals, dated 11/22/16.</p> <p>On 12/13/16 at 11:15 am, LN #3 said the lunch meal was scheduled for 12:00 pm and that she "usually" waits to give sliding scale insulin 30 minutes or less before meals.</p> <p>On 12/13/16 at 11:20 am, LN #3 was observed as she administered Resident #21's rapid acting Novolog insulin.</p> <p>Resident #21's rapid acting insulin was administered 40 minutes before the meal.</p> <p>On 12/14/16 at 2:40 pm, the DNS said NovoLog insulin should be administered 15 minutes or less before a meal.</p> <p>4. Resident #20 was admitted to the facility on 4/15/16, with multiple diagnoses including diabetes mellitus.</p> <p>Resident #20's December 2016 physician orders and MAR included an order for Novolog Flexpen solution 100 units/ml inject per sliding scale subcutaneously two times a day for diabetes.</p>	F 333			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/14/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - WEISER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 EAST PARK STREET WEISER, ID 83672		
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F 333	<p>Continued From page 20</p> <p>The Novolog dose was to be held if Resident #20 was unable to eat the corresponding meal. The sliding scale was as follows:</p> <p>0 - 69 = 0 units, refer to hypoglycemic policy 70 - 80 = 0 units 81 - 100 = 3 units 101 - 150 = 12 units 151 - 200 = 19 units 201 - 250 = 28 units 251 - 300 = 33 units 301 - 350 = 36 units 351 - 400 = 40 units 401+ - 35 units and notify MD if greater than sliding scale range.</p> <p>On 12/14/16 the following observation were made:</p> <p>*11:10 am, LN #1 checked Resident #20's blood sugar level. It was 234.</p> <p>*11:17 am, LN #1 administered 28 units of Novolog insulin to Resident #20.</p> <p>*12:05 pm, Resident #20 was in the dining room waiting for his meal to be served.</p> <p>*12:10 pm, the food trays was being delivered to residents in the dining room.</p> <p>*12:20 pm, Resident #20 was being assisted to eat</p> <p>The Novolog manufacturer documented Novolog (Insulin Aspart) as a rapid acting insulin and an injection of Novolog should immediately be followed by a meal within 5-10 minutes.</p>	F 333			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/14/2016
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - WEISER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 EAST PARK STREET WEISER, ID 83672		
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F 333	Continued From page 21 On 12/14/16 at 2:16 pm, the DNS said, she believed Novolog should be given 15 minutes before meals.	F 333			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001830	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/14/2016
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - W	STREET ADDRESS, CITY, STATE, ZIP CODE 331 EAST PARK STREET WEISER, ID 83672
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	<p>16.03.02 INITIAL COMMENTS</p> <p>A revisit survey conducted at the facility on December 13, 2016 and December 14, 2016.</p> <p>The surveyors conducting the survey were:</p> <p>Linda Kelly, RN, Team Coordinator Presie Billington, RN</p>	{C 000}		

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 01/03/17
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