



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T. – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

February 23, 2017

Peter Smith, Administrator  
Kindred Nursing And Rehabilitation - Caldwell  
210 Cleveland Boulevard  
Caldwell, ID 83605-3622

Provider #: 135014

Dear Mr. Smith:

On **February 8, 2017**, 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 **January 17, 2017**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- **F0248 -- S/S: D -- 483.24(c)(1) -- Activities Meet Interests/Needs of Each Res**
- **F0323 -- S/S: D -- 483.25(d)(1)(2)(n)(1)-(3) -- Free of Accident Hazards/Supervision/Devices**

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 **March 6, 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 **December 20, 2016**, following the survey of **December 2, 2016**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for imposition of a Civil Money penalty effective **December 2, 2106**, Denial of Payment for New Admissions on **March 2, 2017** and termination of the provider agreement on **June 2, 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.**

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.

Peter Smith, Administrator

February 23, 2017

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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 **March 6, 2017**. If your request for informal dispute resolution is received after **March 6, 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,

A handwritten signature in black ink, appearing to read "Nina Sanderson for". The signature is written in a cursive, flowing style.

Nina Sanderson, LSW, Supervisor  
Long Term Care

NS/lj

Enclosures

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

PRINTED: 03/03/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>02/08/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - CALDWELL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>210 CLEVELAND BOULEVARD CALDWELL, ID 83605</b>		
(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 the recertification follow-up and complaint investigation survey conducted at the facility from February 6, 2017 to February 8, 2017.  The surveyors conducting the survey were:  David Scott, RN, Team Coordinator Marci Clare, RN Edith Cecil, RN  Acronyms include: I/A = Incident/Accident MDS = Minimum Data Set	{F 000}			
{F 248} SS=D	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  (c) Activities.  (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure an activities program was provided that met the residents' interests and needs. This was true for 3 of 10 sampled residents (#3, #34, and #35) reviewed for	{F 248}	Resident Specific The Interdisciplinary (ID) team reviewed residents, #3, #34 and #35 and matched their care plans with activity records to reflect their specific MDS preferences.	3/2/17	

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

TITLE

(X6) DATE

Electronically Signed

02/28/2017

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 248}	<p>Continued From page 1</p> <p>activities. This deficient practice had the potential to result in increased behavioral symptoms, worsening of depression, continued or worsening insomnia, and feelings of isolation, due to lack mental stimulation and/or social interaction. Findings include:</p> <p>1. Resident #35 was admitted to the facility 7/21/16, with diagnoses that included a mental disorder of unknown origin, unspecified psychosis, major depressive disorder, vascular dementia, and insomnia.</p> <p>The 7/28/16 Admission MDS Assessment documented newspapers, magazines, listening to music of his own choosing, going outside for fresh air, religious beliefs/practices, and participating in favorite activities were all "very important" to Resident #35.</p> <p>A Quarterly MDS Assessment, dated 1/27/17, documented the following about Resident #35:</p> <ul style="list-style-type: none"> <li>* He had severely impaired cognitive ability</li> <li>* He required extensive assistance of at least two staff for bed mobility, transfers, and toileting</li> <li>* He required extensive assistance of one staff for locomotion on the unit, personal hygiene, and dressing</li> </ul> <p>Resident #35's current Activities Care Plan Goal documented he would "participate in 3-5 in or out of room activities a week [for] 90 days." The goal was initiated on 7/26/16, revised on 2/1/17, and targeted for a successful attainment date of 2/8/17.</p> <p>A Group Activity Participation record for 1/19/17</p>	{F 248}	<p>Other Residents</p> <p>The ID team reviewed other resident activity records to validate that their care plans matched their MDS choices and were reflected on the activity records. Adjustments have been made as indicated.</p> <p>Facility Systems</p> <p>Staff is educated to validate that resident activity choices are met and documented on the activity record. Re-education was provided by the District Director of Clinical Operations, Director of Nursing (DNS) and/or the Staff Development Coordinator (SDC) to include but not limited to, validating residents have their activity choices from the MDS honored, that accommodations are made to meet these desires whether in groups or one-on-one, documentation reflects care provided and have activities that support their physical, mental and psychosocial well-being. The system is amended to include validation that the implementation of the centers activity program match the desires of the residents as noted on the MDS and assist residents meet their desired goals and participation levels.</p> <p>Monitor</p> <p>The Executive Director and/or designee will audit resident activity records to validate resident choices are implemented and documented for 12 weeks. Starting the week of February 26th, 2017 the review will be documented on the PI audit tool. Any concerns will be</p>		

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{F 248}	<p>Continued From page 2</p> <p>through 2/7/19 (19 days) documented Resident #35 participated in "cards/other games" once; "exercise/sports" once; "spiritual/religious activities" once; "talking/conversing/telephone" twice; "social pursuits/special events" twice; "relaxation" six times; and "TV/radio/movies" 26 times.</p> <p>An Activity Participation - 1:1 [one-to-one] monitor for the same time frame documented, "No Data Found."</p> <p>On 2/7/17 at 11:20 am, Resident #35 was observed in the East Dining Room asleep in a wheelchair with his head tipped back and his mouth open. He was in the East Dining Room with 12 other residents and an animated cartoon playing on an overhead television. The scheduled activity at this time, as documented on the February 2017 Activity Calendar posted in resident rooms and common areas, was "Fun Fitness."</p> <p>On 2/8/17 at 12:10 pm, the Activities Director stated the group activity "relaxation" described those times Resident #35 either "napped" or "sat quietly in his room," and that Resident #35 chose to primarily watch television during the 19-day period. The Activities Director stated the facility had "pro-choice" activities and if that (napping, watching TV, sitting quietly room) was what residents wanted to do, facility staff could not force them to participate in other activities.</p> <p>2. Resident #34 was admitted to the facility on 11/4/16, with diagnoses that included delusions and major depressive disorder.</p>	{F 248}	addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		

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{F 248}	<p>Continued From page 3</p> <p>Resident #34's Admission MDS assessment, dated 11/14/16, documented listening to music of her own choosing, animals/pets, news, going outside for fresh air, and participating in her favorite activities were "very important" to her.</p> <p>Resident #34's current Activities Care Plan Goal documented she would "participate in 3-5 in or out of room activities a week [for] 90 days." The goal was initiated on 11/11/16, revised on 11/23/16, and targeted for a successful attainment date of 11/30/16. The care plan interventions directed staff to invite Resident #34 to "activities of choice, interest, music (jazz/soul), crafts, socials, news, activities/walks outside when the weather is good, and religious services..."</p> <p>A Group Activity Participation record for 1/19/17 through 2/7/19 (19 days) documented Resident #34 participated in "talking/conversing/telephone" once; "relaxation" 15 times; and "TV/radio/movies" 18 times. The participation record documented Resident #34 did not participate in activities other than those noted here.</p> <p>On 2/8/17 at 12:10 pm, the Activities Director stated Resident #34 was on a pro-choice activities program and chose only to watch television or relax.</p> <p>3. Resident #3 was admitted to the facility on 10/2/15, and readmitted on 9/7/16, with diagnoses that included vascular dementia with behaviors, unspecified psychosis, bi-polar disorder, major depressive disorder, and Alzheimer's Disease.</p>	{F 248}			

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{F 248}	Continued From page 4  A Significant Change MDS Assessment, dated 1/30/17, documented books, newspapers, magazines, animals/pets, keeping up with the news, and going outdoors for fresh air were all "very important" to Resident #3.  Resident #3's current Activities Care Plan Goal documented she would "participate in 3-5 in or out of room activities a week [for] 90 days." The goal was initiated on 9/7/16 and targeted for a successful attainment date of 12/18/16. The care plan interventions directed staff to invite Resident #3 to "activities of choice, interest, music programs, visits from animals, morning news, group activities, religious services, and activities/walks outside..."  A Group Activity Participation record for 1/19/17 through 2/7/17 (19 days) documented Resident #3 participated in "musical pursuits" once; "spiritual/religious activities" once; "trips shopping/outdoors" once; "card/other games" twice; "reading out loud/audio books" 6 times; "relaxation" 10 times; and "TV/radio/movies" 14 times.  On 2/8/17 at 11:00 am, when asked whether staff provided her with activities that interested her or that she enjoyed, Resident #3 stated, "some of them."  On 2/8/17 at 12:10 pm, the Activities Director again stated the facility offered a pro-choice activities program that did not force residents to participate in activities.	{F 248}			
{F 323} SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	{F 323}		3/2/17	

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{F 323}	Continued From page 5  (d) Accidents. The facility must ensure that -  (1) The resident environment remains as free from accident hazards as is possible; and  (2) Each resident receives adequate supervision and assistance devices to prevent accidents.  (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.  (1) Assess the resident for risk of entrapment from bed rails prior to installation.  (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.  (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of I/A Reports, policies, and resident records, it was determined the facility failed to ensure residents received sufficient supervision to prevent falls. This was true for 1 of 5 sampled residents (#35) reviewed for falls. This deficient practice placed Resident #35 at risk of serious injury and hospitalization when he fell seven times in two months. Findings include:	{F 323}	Resident Specific The ID team reviewed resident #35 to validate his fall prevention care plan is accurate and the appropriate interventions are implemented.  Other Residents The clinical management team reviewed other residents with falls to validate appropriate interventions are in place to		

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{F 323}	<p>Continued From page 6</p> <p>Resident #35 was admitted to the facility on 7/21/16, with diagnoses that included major depressive disorder, vascular dementia, insomnia, lack of coordination, and difficulty walking.</p> <p>A Quarterly MDS Assessment, dated 1/27/17, documented the following about Resident #35:</p> <ul style="list-style-type: none"> <li>* He had severely impaired cognitive ability</li> <li>* He was always incontinent of bladder and frequently incontinent of bowel</li> <li>* He required extensive assistance of at least two staff for bed mobility, transfers, and toileting</li> <li>* He required extensive assistance of one staff for locomotion on the unit, personal hygiene, and dressing</li> <li>* He was not steady and was able to stabilize only with human assistance when transferring from one surface to another, moving from a seated position to a standing position, and when walking</li> <li>* He had experienced two or more non-injury falls since the previous MDS assessment in October 2016</li> <li>* He had experienced one injury-fall since the previous MDS assessment in October 2016</li> </ul> <p>Resident #35's current Falls Care Plan documented the following:</p> <ul style="list-style-type: none"> <li>* Focus - High risk for falls due to confusion, deconditioning, diminished safety awareness, fall risk assessment score, gait/balance problems, incontinence, and history of falls. It documented Resident #35 had, "a[n] actual fall on 1/9/17." The focus area documented an initiation date of 7/21/16 and revision date of 1/12/17.</li> </ul>	{F 323}	<p>prevent accidents and that the care plan is accurate. Updates were made as indicated.</p> <p><b>Facility Systems</b> Staff are educated on prevention of accidents upon hire and annually. Re-education was provided by the DNS and/or SDC to include but not limited to, implementation of plans immediately post fall to prevent further occurrence, timely documentation and update of the care plan, follow-up assessment that addresses the effectiveness of the planned interventions, and neurological assessment for residents with falls. The system is amended to include ID team review in clinical meeting of resident documentation and plans post fall.</p> <p><b>Monitor</b> The DNS and/or designee will audit records of residents with falls for timely interventions, documentation and evaluation of plan effectiveness for 12 weeks. Starting the week February 26th, 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate</p>		

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{F 323}	<p>Continued From page 7</p> <p>* Care Plan Interventions included:</p> <ul style="list-style-type: none"> <li>- 1:1 supervision until further notice (initiated 2/7/17)</li> <li>- Anticipate/meet needs (7/21/16)</li> <li>- Assess for risk of falls (7/21/16)</li> <li>- Place bed against the wall (12/16/16)</li> <li>- Provide appropriate footwear (7/21/16)</li> <li>- Floor mat by bed (12/16/16)</li> <li>- Follow facility fall protocol (7/22/16)</li> <li>- Provide safe environment (7/21/16)</li> <li>- Provide activities that minimize potential for falls (7/21/16)</li> <li>- Keep within staff line-of-sight (1/28/17)</li> <li>- Staff were not to leave the resident alone in his room (1/28/17)</li> <li>- Lock bed brakes (7/22/16)</li> <li>- Move closer to nurse's station with room change (1/12/17)</li> <li>- Toilet every 2-3 hours when awake (12/21/16)</li> <li>- Bed/pressure pad alarms (7/21/16).</li> </ul> <p>An Incident Investigation Directives Post Fall (I/A Report) documented Resident #35 experienced falls on 12/6/16, 12/20/16, and 1/9/17. He subsequently experienced additional falls. These include:</p> <p>* A 1/17/17 I/A Report documented Resident #35 was found on the floor of his bedroom wrapped in his blanket/sheet at 3:30 pm, bleeding from "outside" of his nose and a "bump" over the left eye were noted. The I/A Report documented Resident #35 stated he fell out of bed. Recommended interventions following the fall were to install bed bolsters.</p>	{F 323}			

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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 323}	<p>Continued From page 8</p> <p>A 1/19/17 Progress Note documented, "Plan to place bolsters on the bed to prevent his rolling off in his sleep."</p> <p>The I/A Report and Progress Note did not document when Resident #35 was last toileted (initiated 12/21/16) and that he was still in the same room as he was at the time of his previous falls (initiated 1/12/17). Additionally, there was no documentation that Resident #5's bed/pressure pad alarms were in place or functioning at the time of the fall (initiated 7/21/16).</p> <p>* A 1/24/17 I/A Report documented Resident #35 was found on the floor near his bed at 4:05 pm. A witness statement on the report documented, "I was standing at [the] med cart [and] heard a thud...check[ed] his room...res[ident] laying on floor...res had no apparent injury. He stated he was trying to break out." A second witness statement documented, "Was in dining room when heard nurse yell for help...ran to see what had happened and resident was laying on his back on the floor in his room." The I/A Report documented Resident #35 had last been seen napping in his bed prior to the fall.</p> <p>Recommended interventions included placing a floor mat and directing staff to maintain line-of-sight supervision when Resident #35 expressed a desire to leave the facility.</p> <p>A 1/24/17 Progress Note documented, "Res[ident] has been very agitated the last three days wanting to leave facility to go to an emergency worship service." A 1/26/17 Progress Note documented, "...as the day progresses he becomes increasingly irritable...on rare occasions</p>	{F 323}			

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{F 323}	<p>Continued From page 9</p> <p>he will rise from his wheelchair and walk to the bathroom." A 1/27/17 Progress Note documented, "When he is expressing the desire to leave, we will keep him within line of sight of staff. A fall mat was also added to the care plan."</p> <p>Resident #35 resided in the same room he occupied at the time of the 1/17/17 fall. The I/A Report and the three Progress Notes did not contain documentation related to whether care-planned interventions put into effect prior to 1/24/17 - floor mat, scheduled toileting assistance, pressure alarms - were in place at the time of the fall.</p> <p>* A 1/27/17 I/A Report documented Resident #35 was found at 3:15 pm on the floor near his bed. A witness statement documented, "Heard thud, went into room, resident was on the floor. He said he tried to scoot back in his wheelchair and he fell out."</p> <p>Recommended interventions included staff keeping Resident #35 in line-of-sight (documented as a recommended intervention following the 1/24/17 fall) and not leaving him alone in his room.</p> <p>A 1/28/17 Progress Note documented, "[Resident #35] frequently sits in his doorway, however...he was in his room when he attempted to adjust himself in the wheelchair and fell to the floor. He also has very poor safety awareness. We will continue to...keep [him] within line site (sic) of staff." Another 1/28/17 Progress Note documented, "Res[ident] has no safety awareness." A 2/1/17 Progress Note documented, "He has had several falls, and</p>	{F 323}			

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NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - CALDWELL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>210 CLEVELAND BOULEVARD CALDWELL, ID 83605</b>		
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{F 323}	<p>Continued From page 10</p> <p>continues to insist that he is leaving for a prayer meeting or to preach. [Resident #35] believes he needs to be going somewhere. He can be determined to leave and will not redirect well with staff."</p> <p>Resident #35 continued to reside in the same room he occupied at the time of the 1/17/17 fall and the I/A Report and three Progress Notes did not contain information indicating staff had maintained line-of-sight supervision at the time of the fall.</p> <p>* A 2/3/17 I/A Report documented Resident #35 was found on the floor of his bedroom with a "small welt" to his forehead at 1:30 pm. A witness statement documented Resident #35 "self-propelled to [room after] lunch. Near room [he] tried to stand [and] tripped over foot pedal." A second witness statement documented, "I was helping [in the room next door] and heard a thud, ran to the next room, and [Resident #35] was on the floor by his closet."</p> <p>Recommended interventions included "1:1 [supervision] until further notice."</p> <p>A 2/3/17 Progress Note documented, "Resident [#35] was trying to stand from wheelchair and fell out onto floor. He was found on floor, face down with leg curled under him." A 2/7/17 Progress Note documented, "Resident with [history] of restlessness each early afternoon. Will add 1:1 in the afternoon to address restlessness."</p> <p>The I/A Report and the two Progress Notes did not include documentation that the floor mat, pressure alarms, regularly scheduled toileting,</p>	{F 323}			

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

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{F 323}	<p>Continued From page 11</p> <p>line-of-sight supervision, not leaving Resident #35 unattended in his room, or moving him to a room closer to the nurse's station, had been put into place prior to the 2/3/17 fall. Additionally, the 1:1 supervision documented as a recommended intervention following the 2/3/17 fall, was added to Resident #35's Falls Prevention Care Plan on 2/7/17, four days following the 2/3/17 fall and recommendation.</p> <p>The facility's Fall Response and Management policy, dated 2/14/16, documented staff were to "review information gathered from patient and witness, if applicable. Implement immediate interventions to prevent a repeat fall."</p> <p>On 2/7/17 at 11:20 am, the fall mat was observed in Resident #35's room per the Falls Prevention Care Plan. Resident #35's bed was not equipped with bed bolsters, as recommended after his 1/17/17 fall.</p> <p>On 2/8/17 at 11:40 am, the DNS stated Resident #35's bed had been equipped with a concave mattress rather than bolsters, but his Care Plan had not been amended to reflect the intervention. The DNS acknowledged Resident #5 had not been relocated to a different room as care planned on 1/12/17, staff had not maintained line-of-sight supervision at the appropriate times following the 1/24/17 fall, and staff had not followed care-planned interventions to not leave Resident #35 alone in his room.</p>	{F 323}			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001100</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>02/08/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - C</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>210 CLEVELAND BOULEVARD CALDWELL, ID 83605</b>
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{C 000}	16.03.02 INITIAL COMMENTS	{C 000}		

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>02/28/17</b>
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