



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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March 10, 2017

Terry Parker, Administrator
Kindred Nursing And Rehabilitation - Nampa
404 North Horton Street
Nampa, ID 83651-6541

Provider #: 135019

Dear Ms. Parker:

On **March 1, 2017**, a survey was conducted at Kindred Nursing And Rehabilitation - Nampa by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 20, 2017**. Failure to submit an acceptable PoC by **March 20, 2017**, may result in the imposition of penalties by **April 7, 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; and
- Include dates when corrective action will be completed in column (X5).

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **April 5, 2017 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **May 30, 2017**. A change in the seriousness of the deficiencies on **April 15, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **May 30, 2017** includes the following:

Denial of payment for new admissions effective **May 30, 2017**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 28, 2017**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **May 30, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **March 20,2017**. If your request for informal dispute resolution is received after **March 20,2017**, 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 that reads "D. Scott". The signature is written in a cursive style with a large initial "D" and a smaller "Scott" following it.

David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures

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

PRINTED: 03/29/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/01/2017
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint survey conducted at the facility from February 28, 2017 to March 1, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Brad Perry, BSW, LSW, Team Coordinator Susan Costa, RN</p> <p>Survey Abbreviations: CHF = Congestive Heart Failure CNA = Certified Nursing Assistant COPD = Chronic Obstructive Pulmonary Disease CPAP = Continuous Positive Airway Pressure DON = Director of Nursing HTN = Hypertension LN = Licensed Nurse MAR = Medication Administration Record RN = Registered Nurse SDC = Staff Development Coordinator TAR = Treatment Administration Record UM = Unit Manager</p>	F 000	<p style="text-align: center;">RECEIVED APR 05 2017 FACILITY STANDARDS</p> <p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Health & Rehabilitation – Nampa 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>		
F 323 SS=D	<p>483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>(d) Accidents. The facility must ensure that -</p> <p>(1) The resident environment remains as free from accident hazards as is possible; and</p> <p>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or</p>	F 323	<p>F323 Resident Specific The clinical management team reviewed resident #1 and updated his care plan to his current fall prevention plan. Rounds validate that plans are implemented.</p> <p>Other Residents The clinical management team reviewed other residents with falls and/or alarms. Interventions were reviewed and revised as necessary to address current fall prevention needs. Rounds validate that plans are implemented.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed TITLE: Executive Director (X8) DATE: _____

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 323	<p>Continued From page 1</p> <p>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.</p> <p>(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>(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, record review, and staff interviews, it was determined the facility failed to ensure fall prevention interventions were followed. This was true for 1 of 2 residents (#1) sampled for falls. The deficient practice had the potential for harm if falls resulted in a significant injury. Findings include:</p> <p>Resident #1 was readmitted to the facility on 1/14/17, with multiple diagnoses including a history of falls.</p> <p>Resident #1's current Risk for Falls care plan documented a 11/15/16 intervention to have tab alarms while he was in bed and in his wheelchair.</p> <p>Resident #1's 12/20/16 Care Plan record documented, "Family is requesting alarm-in place."</p> <p>Resident #1's 1/15/17 Fall Risk Assessment documented he was at risk for falls.</p>	F 323	<p>Facility Systems</p> <p>The IDT team is educated to review fall prevention plans on admission, re-admission, post fall, and with a change of condition. Licensed nurses are educated to update the fall prevention plans, communicate the plan to the care givers, and monitor plan implementation at the bedside. Re-education was provided by the Staff Development Coordinator (SDC) and/or Director of Nursing Services (DNS) to include but not limited to, updating fall plans with re-admission, fall prevention plans communication to the care givers, and fall prevention plan implementation. The system is amended to include review of the care plan with re-admission and validation that care giver communication is implemented during clinical meeting. Rounds will include validation of plan implementation at the bedside.</p> <p>Monitor</p> <p>The DNS and/or designee will review 2 residents with fall history and/or risk and their care plans to validate fall interventions are correctly implemented weekly for 8 weeks. Starting the week of April 6th, the review will be documented on the performance improvement (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 90 days, as it deems appropriate.</p> <p>Date of Compliance April 6, 2017 <i>April 13, 2017</i> <i>per email of 4-12-17.</i></p>	

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F 323	<p>Continued From page 2</p> <p>On 2/28/17 at 12:00 pm, Resident #1 was observed in his wheelchair in the dining room without a tab alarm on his wheelchair.</p> <p>On 2/28/17 at 2:29 pm, Resident #1 was observed asleep in his lowered bed with a tab alarm clipped to his shirt and a fall mat next to the bed.</p> <p>On 3/1/17 Resident #1 was observed at the following times: -8:13 am, he was observed to be wheeled down to the dining room in his wheelchair by CNA #1. There was no tab alarm on his wheelchair. -8:55 am, he was in the dining room in his wheelchair without a tab alarm on his wheelchair. -9:40 am, he was in his wheelchair, in his room, with the TV on, without a tab alarm on his wheelchair and he appeared to be drowsy.</p> <p>On 3/1/17 at 9:50 am, CNA #1 said he helped get Resident #1 ready that morning and was not aware he used a tab alarm in his wheelchair. CNA #1 said he was aware Resident #1 used a bed alarm because of fear of him rolling out of bed.</p> <p>On 3/1/17 at 9:55 am, CNA #1 and CNA #2 were observed to transfer Resident #1 from his wheelchair to his bed. After in bed, CNA #1 clipped the tab alarm to the resident's shirt, lowered the bed and placed a fall mat next to the bed.</p> <p>On 3/1/17 at 11:52 am and 3:00 pm, the DON with the SDC present, was made aware of the observations of the tab alarm and said she would expect staff to follow Resident #1's care plan. The DON said she looked into the situation and said</p>	F 323		

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F 323	Continued From page 3 the wheelchair alarm intervention should have been taken off the care plan when Resident #1 was readmitted to the facility on 1/14/17, and he did not really need the alarm on the wheelchair. On 3/1/17 at 3:20 pm, UM #1 said according to the care plan, Resident #1 should have a bed and wheelchair alarm. She said there was some confusion on what fall interventions were currently in place. She said the facility used pressure pad alarms in residents' beds rather than tab alarms and Resident #1 had not used a pressure pad bed alarm for a while. UM #1 said CNA staff may have been using Resident #1's wheelchair tab alarm on the bed rather than transferring it back and forth from the bed and wheelchair.	F 323			
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the	F 328	F328 Resident Specific Resident #2 has been discharged. Other Residents The clinical management team reviewed other residents with care for special needs – nebulizer treatment, g-tube care, and CPAP machines. Treatment schedules have been initiated as indicated. Facility Systems Licensed nurses are educated to document on the Medication/Treatment Administration Record (MAR/TAR). Re-education was provided by the SDC and/or DNS to include but not limited to, documentation of non-medication entries with validation during shift-to-shift report. The system is amended to include review of the MAR/TAR in clinical meeting to validate completion.		

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F 328	<p>Continued From page 4 comprehensive person-centered care plan, and the resident's goals and preferences.</p> <p>(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.</p> <p>(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.</p> <p>(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure resident monitoring was provided consistent with</p>	F 328	<p>Monitor The Medical Records Clerk and/or designee will audit 5 MAR/TAR weekly for 8 weeks. Starting the week of March 20th, 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 90 days, as it deems appropriate.</p> <p>Date of Compliance April 6, 2017</p>	

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F 328	<p>Continued From page 5</p> <p>physician orders. This was true for 1 of 4 sampled residents (#2) reviewed for documentation of monitoring as ordered. The deficient practice created the potential for harm if Resident #2 developed medical complications resulting from lack of nursing assessments and monitoring. Findings include:</p> <p>Resident #2 was admitted to the facility on 6/22/16, with diagnoses which included chronic respiratory failure, CHF, COPD, HTN, protein calorie malnutrition, peripheral vascular disease, osteomyelitis [bone infection], and acute renal failure. Resident #2 was noted to have 8 hospitalizations in a 4 month period. The 3 most recent transfers to a hospital were on 1/24/17, 2/15/17 and 2/19/17.</p> <p>On 1/24/17, Resident #2 was transferred to the hospital after lab results showed low sodium and potassium levels. She returned to the facility on 1/31/17.</p> <p>Resident #2 was transferred to the hospital on 2/15/17, for a planned gastrostomy tube placement. A gastrostomy tube is a device placed through the abdominal wall, into the stomach, and through which enteral [nutritionally complete] feedings may be administered to increase nutritional/calorie intake. The transfer was a planned transfer, not a decline in status.</p> <p>Resident #2's most recent hospitalization was on 2/19/17, which was due to abdominal pain and his request to go to the hospital to have it assessed.</p> <p>Resident #2's record included a physician order, dated 2/18/17, for gastrostomy tube care daily, which included cleansing, application of</p>	F 328		

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F 328	<p>Continued From page.6</p> <p>Bacitracin [ointment used to prevent or treat infection], and application of a new dressing. The order included monitoring of the gastrostomy site daily for changes. Resident #2's TAR included documentation on 2/19/17. The gastrostomy tube care was not documented as done on 2/18/17.</p> <p>Resident #2's MAR for February 2017, included an order for DuoNeb Solution [an inhaled breathing treatment]. The MAR order included monitoring of breath sounds, documentation of the duration of the treatment [minutes], oxygen saturation levels [the amount of oxygen in the blood], and initials of the individual administering the medication. The nursing staff failed to document monitoring of the following:</p> <ul style="list-style-type: none"> - Breath sounds from 2/1/17 to 2/17/17, - Duration of treatment from 2/1/17 to 2/3/17, and 2/7/17 to 2/16/17, - Oxygen saturations from 2/1/17 to 2/16/17. <p>Resident #2's MAR for February 2017, included an order for assessment of her nebulizer breathing treatments and documentation of the findings. A nebulizer is a machine that changes medication from a liquid to a mist so that it can be more easily inhaled into the lungs. The order was dated 1/31/17, and stated staff was to record the number of minutes spent on assessment and treatment. The MAR for the monitoring and documentation of the treatments included areas to document pre-assessments, post treatment assessments, minutes of assessment and treatment, pulse, respirations, oxygen saturations, and if the treatments were prn [as needed]. The MAR did not include documentation of assessment of Resident #2's nebulizer treatments from 2/1/17 to 2/19/17.</p>	F 328		

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F 328	Continued From page 7 Resident #2's care plan for Altered Respiratory Status, included documentation of non-compliance with using a CPAP [continuous positive airway pressure] machine. A CPAP machine is used for respiratory ventilation, often used to treat sleep apnea and individuals who have difficulty taking deep breaths, or other respiratory needs. The care plan interventions included, "Encourage to use CPAP as ordered. Document non-compliance." The CPAP machine and monitoring Resident #2's non-compliance or compliance with its use was not included and documented on the MAR or TAR. The DON and SDC reviewed Resident #2's record and Resident #2's nebulizer assessments were not documented on the MAR, and therefore, not completed as ordered. The DON stated she knew Resident #2 had a CPAP machine and was non-compliant with its use. She confirmed Resident #2's MAR and TAR did not include use of the CPAP and monitoring of her use of it. The DON and SDC were unable to provide supportive documentation of further monitoring. The facility failed to monitor Resident #2's CPAP use, respiratory status, and gastrostomy site care, as ordered.	F 328			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001550	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/01/2017
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - N.	STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651
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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>The following deficiencies were cited during the complaint survey of your facility completed from February 28, 2017 to March 1, 2017.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Susan Costa, RN</p> <p>Abbreviations: RN = Registered Nurse</p>	C 000	<p style="text-align: center;">RECEIVED MAR 20 2017 FACILITY STANDARDS</p>	
C 762	<p>02.200,02,c,ii When Average Census 60-89 Residents</p> <p>ii. In SNFs with an average occupancy rate of sixty (60) to eighty-nine (89) patients/residents a registered professional nurse shall be on duty for each a.m. shift (approximately 7:00 a.m. - 3:00 p.m.) and p.m. shift (approximately 3:00 p.m. to 11:00 p.m.) and no less than a licensed practical nurse on the night shift.</p> <p>This Rule is not met as evidenced by: Based on review of a three-week nursing schedule provided by the facility, it was determined the facility did not meet the State requirement for RN coverage when the resident occupancy rate was between 60 and 89 residents for each of the days reviewed. Inadequate RN coverage had the potential to negatively affect all residents living in the facility. Findings include:</p>	C 762	<p>C762 Resident Specific No specific residents were cited.</p> <p>Other Residents Resident population is affected. No current negative outcomes identified.</p> <p>Facility Systems Continue to advertise, interview, hire, and orient registered nurses (RN) to provide am and pm shift coverage daily. The schedule is completed with current staff, agency is contacted to fill additional vacancies as able. The system is amended to include clinical management team rotation to cover unfilled pm shifts for RN coverage.</p>	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed



TITLE

Executive Director

(X6) DATE

3-17-17

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001550	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/01/2017
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - N.		STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
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C 762	<p>Continued From page 1</p> <p>The three-week nursing schedule for 1/8/17 through 1/28/17, for RN coverage, documented there was no RN coverage on the Evening Shift on the following days:</p> <ul style="list-style-type: none"> * 1/11/17- The resident census was 70. * 1/18/17- The resident census was 76. * 1/19/17- The resident census was 74. * 1/24/17- The resident census was 68. * 1/27/17- The resident census was 73. <p>On 3/1/17 at 8:45 am, the Administrator confirmed there were not eight hours of RN coverage for the shifts above. She said the facility had trouble finding RNs to work in the facility, including RNs from local agencies.</p>	C 762	<p>Monitor</p> <p>The Executive Director (ED) and/or designee will validate schedule has RN coverage for am and pm shifts weekly for 8 weeks. The review will be evident on the nursing schedule. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 90 days, as it deems appropriate.</p> <p>Date of Compliance April 5, 2017</p>	



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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May 19, 2017

Jeff Corriher, Administrator
Kindred Nursing And Rehabilitation - Nampa
404 North Horton Street
Nampa, ID 83651-6541

Provider #: 135019

Dear Mr. Corriher:

On **March 1, 2017**, an unannounced on-site complaint survey was conducted at Kindred Nursing And Rehabilitation - Nampa. The complaint was investigated during an on-site complaint investigation survey conducted from February 28, 2017 to March 1, 2017.

Residents' meals were observed for food and drink choices and for fall prevention throughout the survey.

The clinical records of the identified residents and three other residents were reviewed for quality of care concerns. The facility's Grievance file from November 2016 to February 2017, Resident Council minutes from February 2016 to January 2017, the facility's Incident and Accident reports for July and August 2016 and November 2016 to February 2017, and the facility's Allegation of Abuse reports from 11/1/16 to February 2017 were reviewed.

Several residents, several nursing staff, the Director of Nursing, the Staff Development Coordinator, and the Certified Dietary Manager were interviewed regarding quality of care and nutrition concerns.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007411

ALLEGATION #1:

The Reporting Party said an identified resident complained of painful urination during a specific time period and the facility failed to act timely to assess the resident.

FINDINGS:

The facility's Grievance file from November 2016 to February 2017 and Resident Council minutes from February 2016 to January 2017 did not document a concern with delay of treatment or urinary issues. The identified resident and three other residents' clinical records were reviewed for delay of treatment and urinary issues and no concerns were identified.

Several nurses, CNAs and the Director of Nursing said there were no concerns with delay of treatment or urinary concerns with either the identified resident or other residents in the facility.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

An identified resident did not receive cranberry juice with every meal as requested.

FINDINGS:

The identified resident was observed for two meals and the resident received cranberry juice for each meal. Several other residents' meals were observed and no concerns were identified. Several staff were observed to check residents' meal cards to verify the residents received what was on the cards.

The identified resident's meal card documented the resident was to receive cranberry juice for each meal.

Several residents said they received what they ordered with their meals. Several CNAs said they checked to make sure the meal cards matched what residents had on their trays. The Certified Dietary Manager said meal cards are audited to make sure they matched the residents orders and then during meal service the meal cards are checked by the cook, the dietary aides and the CNAs, to make sure the residents received what they are supposed to.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Jeff Corriher, Administrator
May 19, 2017
Page 3 of 4

ALLEGATION #3:

Facility staff were not aware of and were not following an identified resident's fall care plan regarding alarms.

FINDINGS:

The identified resident and one other resident were observed for fall prevention interventions during the survey.

The identified resident and one other resident's clinical records were reviewed for fall preventions. The facility's Incident and Accident reports for July and August 2016 and November 2016 to February 2017 were reviewed.

One resident, two CNAs, a nurse Unit Manager, the Director of Nursing and the Staff Development Coordinator were interviewed regarding fall prevention measures.

Based on observation, record review and staff interview, it was determined the allegation was substantiated and the facility was cited at F323.

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,

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

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

DS/lj



IDAHO DEPARTMENT OF
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May 24, 2017

Jeff Corriher, Administrator
Kindred Nursing And Rehabilitation-- Nampa
404 North Horton Street
Nampa, ID 83651-6541

Provider #: 135019

Dear Mr. Corriher:

On **March 1, 2017**, an unannounced on-site complaint survey was conducted at Kindred Nursing And Rehabilitation - Nampa. The complaint was investigated during an on-site complaint investigation survey conducted from February 28, 2017 to March 1, 2017.

Nurses and Certified Nurse Aides (CNAs) were observed throughout the survey. Call light response times and resident requests to staff were also observed throughout the survey.

The clinical records of two identified residents were reviewed for quality of care concerns. Two other residents' records were reviewed for quality of care concerns. Three weeks of nursing schedules were reviewed for RN coverage. The facility's Grievance file from November 2016 to February 2017, Resident Council minutes from February 2016 to January 2017, the facility's Incident and Accident reports from November 2016 to February 2017, and the facility's Allegation of Abuse reports from November 2016 to February 2017 were also reviewed.

Several residents, nursing staff, the Director of Nursing, and the Staff Development Coordinator were interviewed regarding quality of care concerns. The Administrator was interviewed regarding staffing concerns.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007459

ALLEGATION #1:

The Reporting Party said there was insufficient Registered Nurse (RN) staffing coverage for the facility.

FINDINGS:

Based on record review and interview with the Administrator, it was determined the allegation was substantiated and the facility was cited at C762.

CONCLUSIONS:

Substantiated. State deficiencies related to the allegation are cited.

ALLEGATION #2:

The facility used local agency nurses and CNAs who came to work tested positive for illicit drug usage.

FINDINGS:

Several nurses and CNAs were observed for indications of illicit drug usage and no concerns were identified.

Several nurses and CNAs said if a co-worker was suspected of using illicit drugs, that would be reported immediately to the charge nurse or Director of Nursing. The Director of Nursing said the facility used a drug screen checklist if any employee, including agency staff, appeared to be using illicit drugs. The Director of Nursing said there were no employees who had come to work in a drug-induced state that she was aware of and if she became aware of any employee, including agency staff, who had been in that situation, they would be drug tested and sent home pending laboratory results.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Call lights were not answered in a timely fashion, especially on night shift and when they were answered, staff often turned the call lights off without assisting residents until the residents turned the call lights back on again.

FINDINGS:

Call light response times and resident requests to staff were observed throughout survey and no concerns were identified.

The facility's Grievance file from November 2016 to February 2017, Resident Council minutes from February 2016 to January 2017, and Allegation of Abuse reports from November 2016 to February 2017 did not document any concerns with call light response times.

Several residents said call lights were answered in a timely manner both day and night. Several nurses, CNAs and the Director of Nursing said call lights were answered and the lights remained on until the residents' needs had been met.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Nursing staff failed to assess and treat residents which resulted in hospital transfers, including one resident with worsening respiratory status, a resident who required an amputation, and a resident with chest pains.

FINDINGS:

Four records were reviewed. Two residents were transferred due to medical complications, which required a higher level of care.

1. An identified resident admitted to the facility with diagnoses of chronic respiratory failure, Chronic Heart Failure, Chronic Obstructive Pulmonary Disease, hypertension, protein malnutrition, peripheral vascular disease, osteomyelitis, and acute renal failure was noted to have eight hospitalizations in a four-month period.

The allegation was substantiated and the facility was cited at F328. Please refer to federal report 2567 for details.

2. A second identified resident admitted to the facility with diagnoses of Peripheral Vascular Disease, Atrial-Fibrillation, hypertension, and anemia was transferred to a hospital, where he/she required multiple surgical interventions related to the development of acute ischemia in the lower leg. The resident medical record did not indicate a failure of nursing assessments contributed to the resident's hospitalization and subsequent amputation of the lower leg.
3. There was no evidence reviewed during survey substantiating that an identified resident was admitted to a hospital with chest pain as a result of inadequate nursing care.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #5:

An identified resident receiving hospice services was over-medicated.

FINDINGS:

A review of the facility's Incident Reports, observations of staff and residents, and multiple interviews with nursing staff failed to reveal any incidents related to excessive medication administration. There were no residents receiving hospice services at the time of the investigation.

A Licensed Nurse demonstrated the electronic Medication Administration Record system and attempted to dispense a medication dose other than what was ordered. The system provided an alert to the nurse, which required him/her to override the medication dose order. He/She stated the override would generate a report to the pharmacy. The nurse stated all medications, including controlled medications, were reconciled with another nurse during shift change and upon delivery of additional medications to the medication cart. He/She stated the reconciliation process would identify medication errors.

Based on observation, record review, and staff interview, the allegation could not be substantiated for lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Jeff Corriher, Administrator
May 24, 2017
Page 5 of 5

ALLEGATION #6:

CNA staff did not know how to perform Cardiopulmonary Resuscitation (CPR).

FINDINGS:

The facility's policy documented CNAs were not required to have CPR certification.

Several CNAs said they would immediately inform the nurse if they found a resident who was unresponsive, so they could evaluate and assess the resident. The Director of Nursing said the facility did not require CPR certification for CNAs, but provided CPR training for anyone who wanted it and several staff other than CNAs and nurses were CPR certified.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

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

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

DS/lj