



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7012 1010 0002 0836 1802

March 13, 2014

Debbie Freeze, Administrator
Kindred Transitional Care & Rehabilitation - Lewiston
3315 8th Street
Lewiston, ID 83501-4966

Provider #: 135021

Dear Ms. Freeze:

On **February 28, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Kindred Transitional Care & Rehabilitation - Lewiston by the Department of Health & Welfare, 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 actual 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, and a similar State Form 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 in column X5 Complete Date, to signify when you allege that each tag will be back in compliance.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION.

Debbie Freeze, Administrator
March 13, 2014
Page 2 of 4

After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 26, 2014**. Failure to submit an acceptable PoC by **March 26, 2014**, may result in the imposition of civil monetary penalties by **April 15, 2014**.

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

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title, who will do the monitoring. It is important that the individual doing the monitoring have the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for "random" audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- Include dates when corrective action will be completed in column 5.

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.

Debbie Freeze, Administrator
March 13, 2014
Page 3 of 4

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

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

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 28, 2014**, 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 these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (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. 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)

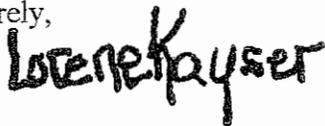
Debbie Freeze, Administrator
March 13, 2014
Page 4 of 4

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

This request must be received by **March 26, 2014**. If your request for informal dispute resolution is received after **March 26, 2014**, 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, please contact us at (208) 334-6626.

Sincerely,

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

LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LKK/dmj
Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135021	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 2/28/2014
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - LEWI	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 278	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, it was determined the facility did not ensure bowel function was accurately coded on an MDS assessment. This was true for 1 of 9 (Resident #1) residents sampled for MDS accuracy. Findings included:</p> <p>Resident #1 was admitted to the facility on 10/24/13 with multiple diagnoses which included left hip fracture, chronic ischemic heart disease and hypertension.</p> <p>Resident #1's Admission MDS assessment, dated 10/31/13, coded the resident as always continent of bowel.</p> <p>Resident #1's Quarterly MDS assessment, dated 12/19/13, coded frequently incontinent of bowel.</p> <p>On 2/25/14 at 10:30 AM, Resident #1 was asked about the amount of assistance she needed, and whether or not that assistance was provided. The resident stated she felt help was always available, although, "I don't always ask for it." The resident stated at times, when she did not ask for help in time, she had, "accidents."</p> <p>On 2/26/14 at 11:35 AM, the DNS was asked about the apparent decline in Resident #1's bowel continence, per the MDS data. The DNS stated she would have to research further.</p> <p>On 2/27/14 at 9:50 AM, the DNS returned with additional information. The DNS provided the ADL flow sheets for the MDS look-back periods for both MDS's. The flow sheets both documented the resident had</p>		

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

The above isolated deficiencies pose no actual harm to the residents

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"A" FORM

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - LEWI	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 278	<p>Continued From Page 1</p> <p>been incontinent of bowel on two occasions during each look-back period. The DNS stated, "The initial MDS should have coded her to be frequently incontinent of bowel. There was no decline, it was just mis-coded on the first MDS." The DNS stated the resident's next Quarterly MDS was currently in process, so her bowel patterns were being reviewed again.</p> <p>On 2/27/14 at 4:15 PM, the Administrator, DNS, and DDCO were informed of the surveyor's findings. The facility offered no further information.</p>		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/28/2014
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 3315 6TH STREET LEWISTON, ID 83501	
(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 annual recertification and complaint survey at your facility. The team entered the facility on 2/24/14 and exited on 2/28/14. The survey team included: Nina Sanderson, LSW BSW, Team Coordinator Brad Perry, LSW BSW Amy Barkley, RN BSN Lauren Hoard, RN BSN Jana Duncan, RN MSN</p> <p>Survey definitions are: ADL = Activities of Daily Living AROM = Active Range of Motion BIMS = Brief Interview of Mental Status BWAT = Bates-Jensen Wound Assessment Tool CHF = Congestive Heart Failure CMS = Centers for Medicare and Medicaid Services COPD = Chronic Obstructive Pulmonary Disease CNA = Certified Nurses Assistant CVA = Cerbrovascular Accident CT = Computerized Tomography DDCO = Divisional Director of Clinical Operations DNS/DON = Director of Nursing Drsg = Dressing EMR = Electronic Medical Record ER = Emergency Room IDT = Interdisciplinary Team MD = Physician MDS = Minimum Data Set MI = Myocardial Infarction mg = milligrams mcg = micrograms ORIF = Open Reduction Internal Fixation PROM = Passive Range of Motion PU = Pressure Ulcer</p>	F 000		

RECEIVED
MAR 25 2014
FACILITY STANDARDS

*per conversation
w admin 1/13/14
1:10pm
3/24/14*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Debbie Hege* TITLE *Executive Director* (X6) DATE *3-26-14*

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 000 F 157 SS=D	<p>Continued From page 1</p> <p>PVD = Peripheral Vascular Disease PRN = As needed pt = Patient QOD = Every other day RD = Registered Dietician roho = pressure relieving wheelchair pad SBAR = Situation, Background, Assessment, and Request SDC = Staff Development Coordinator s/s = Signs and Symptoms tx = Treatment</p> <p>483 10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident, consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment), or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2), or a change in resident rights under Federal or State law or</p>	F 000 F 157	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Lewiston Rehabilitation & Care Center 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>F157</p> <p>Resident Specific The ID team reviewed resident #1. MD has been notified of weight changes. No new orders obtained</p> <p>Other Residents The ID team reviewed weight report and chart audits for other at risk. No other residents identified. Education provided regarding policy of timely notification of any changes to MD, resident and family member. Adjustments have been made as indicated.</p> <p>Facility Systems Licensed Nurses are educated to policy of notification to MD, family and resident of</p>	

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F 157	<p>Continued From page 2</p> <p>regulations as specified in paragraph (b)(1) of this section</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interview, it was determined the facility did not ensure a resident's Physician was notified of changes in her weight and appetite. This was true for 1 of 2 (R #1) residents sampled for weight loss. The deficient practice had the potential to cause more than minimal harm if the resident continued to experience these changes without evaluation by her Physician. Findings included:</p> <p>Resident #1 was admitted to the facility on 10/24/13 with multiple diagnoses which included left hip fracture, chronic ischemic heart disease and hypertension.</p> <p>Resident #1's admission MDS assessment, dated 10/31/13, documented a height of 61 inches and a weight of 124 pounds.</p> <p>Resident #1's most recent quarterly MDS assessment, dated 12/19/13, coded moderately impaired cognition, weight of 103 pounds, and a weight loss of greater than 5% [percent] in one month which was not prescribed by a Physician.</p> <p>Resident #1's Physician's progress notes documented 11/4/13. The area to document the resident's weight was blank. No mention was made of her</p>	F 157	<p>any changes in condition. Re-education was provided to include but not limited to, notification to MD, family, and resident when changes in condition are noted.</p> <p>Monitor The DNS or designee will audit new orders to ensure documentation for MD, family and resident notification is present 3 times a week then weekly for 4 weeks. The review will be documented on the PI audit tool. Starting 4/3/14 any concerns will be addressed immediately and Identified trends discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p> <p style="text-align: right;">4-3-14</p>

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F 157	<p>Continued From page 3</p> <p>nutrition, weight, or eating habits. [NOTE: The resident's Weights and Vitals Summary (WVS) form documented weights of 122.8 pounds on 10/31/13, 118.8 pounds on 11/7/13]</p> <p>*12/10/13. The area to document the resident's weight was blank. The body of the assessment documented. "She seems to be eating at least regular." [NOTE: The resident's WVS form documented a weight of 103 pounds on the date of this Physician's visit, down 21.4 pounds since her admission on 10/24/13.]</p> <p>*1/14/14. The area for the resident's weight documented. "Patient presents in a wheelchair, no height or weight measurement." [NOTE. The resident's WVS form documented her most recent weight before this visit was 96 pounds, down 7 pounds from her previous Physician visit and 28.4 pounds since her admission to the facility 10/24/13.]</p> <p>*2/11/14. The area to document the resident's weight was blank. There was no further mention of the resident's weight or nutritional status in the narrative portion of the progress note. [NOTE. The resident's WVS form documented a weight of 103.8 pounds the day before this visit, consistent with the weight documented on that form 12/10/13.]</p> <p>On 2/25/14 at 10:30 AM, R #1 was interviewed about her care in the facility. R #1 reported she did not have much of an appetite, and was often offered more food that she wanted to eat. R #1 attributed her appetite decline to her advanced age.</p> <p>On 2/26/14 at 12:20 PM, the RD was interviewed about R #1's weight loss. The RD stated "The resident had a previous admission to the facility, but was discharged to the community in</p>	F 157	

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F 157	Continued From page 4 early October, 2013. During her previous admission, the resident was historically underweight but had a slight planned weight gain. *The RD had identified the resident's usual body weight ranged from 101 pounds to 104 pounds. *When the resident was re-admitted to the facility on 10/24/13, her weight was significantly elevated as compared to baseline, which the facility attributed to the presence of edema. Initially upon re-admission, the resident's appetite was stable, then her edema began to resolve and her weight declined as expected. *In mid-December 2013, the facility noted a decline in the resident's appetite, in addition to continued decline in her weight. The RD recommended, and the facility started, "enriched meals", which added extra calories to some of the food items offered to the resident. The resident was weighed weekly, and her weight stabilized until 1/7/14. *When weighed on 1/7/14, there was a noted decrease in her weight and in her meal intakes. The facility determined the resident was having more difficulty staying on task during the meal. The facility offered to place the resident in a dining environment with more cueing available, but the resident refused. *The resident was weighed on 1/14/14, with further decline noted. The facility arranged for additional cueing to be offered in the dining environment of her preference. *By 2/13/14, the RD had determined the resident's weight to be stabilizing. The resident had agreed to move to a more structured dining setting, and her intakes had improved 10 percent. *At the time the RD was interviewed, the resident's weight was 104 pounds. The RD stated this weight was consistent with the resident's weights from a year ago, and up from a low	F 157		

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F 157	Continued From page 5 weight of 96 pounds. The RD was asked if the Physician had ever been notified of the facility's concerns with the resident's weights, their interventions in response to those concerns, or the effectiveness of those interventions. The RD stated she would have to investigate further. On 2/27/14 at 9:50 AM, the DNS reported the facility did not have proof the Physician had been notified of the resident's weight or appetite changes at the time they were occurring. The DNS stated they had contacted the Physician that day (2/27/14), and the Physician would be willing to provide a statement regarding the need to honor the resident's advanced directives. On 2/27/14 at 4:15 PM, the Administrator, DNS, and DDCO were informed of the surveyor's findings. The facility offered no further information.	F 157	
F 225 SS=D	483 13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	F 225	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Lewiston Rehabilitation & Care Center 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.

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F 225	<p>Continued From page 6</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility did not attempt to ascertain the unknown cause of a resident's hip fracture. This was true for 1 of 10 residents (#14) sampled for incident investigations. Failure to ensure all injuries of unknown origin were thoroughly investigated placed the resident at risk for abuse or neglect. Findings included:</p> <p>Resident #14 was admitted to the facility on 1/4/13 with multiple diagnoses which included CHF, COPD, severe osteoporosis, severe PVD, seizure disorder, malnutrition, and a history of</p>	F 225	<p>Resident Specific The ID team reviewed resident #14. Resident was discharged from facility prior to annual survey</p> <p>Other Residents The ID team reviewed/investigated other residents at risk for injuries of unknown origin thru review of last 30 days incident reports and weekly skin checks No other residents identified.</p> <p>Facility Systems Licensed Nurses are educated to investigate injuries of unknown origin. Re-education was provided to include but not limited to, definition of injury of unknown origin and required reporting.</p> <p>Monitor The ED/DNS or designee will audit any new incidents for root cause 5 times weekly or as incidents occur for 8 weeks. The review will be documented on the PI audit tool, starting 4/3/14. Any concerns will be addressed immediately and identified trends discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p>	4-3-14

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

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F 225	<p>Continued From page 7</p> <p>both right and left hip fractures with ORIF to each hip.</p> <p>Resident #14's Quarterly MDS assessment, dated 4/15/13, coded: *Moderately impaired cognitive skills; *Dependent on 2 person assist with transfers and toileting; *Extensive assistance of 1 for wheelchair mobility, dressing, eating, and hygiene; *Did not ambulate, and *No known history of falls, and no falls since admission</p> <p>Facility Post Fall Investigation forms for Resident #14 documented: *4/29/13 at 9:25 PM, rolled out of bed. An IDT note regarding the fall, dated 5/1/13 at 11:04 AM documented, "...It appears that resident attempted to reposition self and half slid out of bed. Bruise noted to left wrist, no other injuries noted... SBAR sent to MD with request top review/advise." The MD responded to call if there were any problems. *5/6/13 at 5:45 PM, rolled out of bed. An IDT note regarding the fall, dated 5/9/13 at 9:49 AM documented, "...It appears that resident rolled out of bed AROM and PROM with no apparent s/sx [signs or symptoms] of injury noted...sent to ER for eval, no fractures noted..." The facility documented body pillows would be added for positioning when the resident was in bed.</p> <p>On 5/7/14, an Emergency Department Patient Visit Information form documented, "Osteoporosis of [right] hip no [fracture] seen on CT"</p> <p>No further falls were documented for this</p>	F 225		

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F 225	<p>Continued From page 8 resident.</p> <p>On 5/25/13 at 8:04 PM, a Nurse's Progress Note for Resident #14 documented, "Resident noted to have 3-4 plus taught [sic] edema to foot extending to above [right] knee, also [complains of] increase pain to [right lower extremity], especially [with] movement...[Physician's name] contacted... ordered resident transferred to [Name of Hospital] ER for evaluation and treatment."</p> <p>On 5/31/13, a hospital discharge summary documented the resident had been admitted to the acute care hospital on 5/25/13, for a diagnosis of a right hip fracture. The discharge summary documented, "...The patient is returning to [Name of Facility] nursing home...The patient had fallen and broken his right hip..."</p> <p>On 5/31/13, facility Nurse's Progress Notes documented the resident passed away at 7:20 PM.</p> <p>On 2/27/14 at 11:30 AM, the DNS was asked about Resident #14's hip fracture. The DNS stated after the resident's fall on 5/6/13, he had no changes in his range of motion to his extremities. The day following the fall, the resident went to his physician, who sent him to the ER for evaluation of a possible hip fracture. At the ER, a CT scan determined no fracture was present. The DNS stated until the day of his discharge, the resident only complained of pain in his left lower extremity, as was customary for him due to a vascular wound, and his pain was successfully managed with the medications available to the resident. The DNS stated per her recollection, the resident went to the wound clinic on the day his fracture was diagnosed, then sent</p>	F 225		

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F 225	Continued From page 9 to the ER from there and admitted to the hospital. The DNS was asked what the facility had determined to be the cause of the resident's fracture. The DNS stated since the resident's most recent fall prior to the fracture was on 5/6/13, and a CT was negative for fracture on 5/7/143, the facility did not feel the need to investigate further. [NOTE: Facility nurse's notes documented the resident was sent directly to the ER from the facility, on the evening of 5/25/13.] The DNS was unable to explain what had caused the fracture. On 2/27/14 at 4:15 PM, the Administrator, DNS, and DDCCO were informed of the surveyor's findings. The facility offered no further information.	F 225		
F 248 SS=E	483 15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, group resident interview and staff interview, the facility failed to provide an ongoing program of activities to include sufficient activities in the evenings and on weekends. This was true for 4 of 6 residents who attended the group meeting and had the potential to affect most residents in the facility. This created a potential for psychological harm when residents were provided minimal activities which could	F 248	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Lewiston Rehabilitation & Care Center 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.	

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F 248	<p>Continued From page 10</p> <p>potentially create an atmosphere of boredom and foster an increase in negative behaviors Findings included</p> <p>The Activity Calendars for November and December 2013 and January and February 2014 were reviewed. The calendars lacked enough scheduled activities throughout the day to maintain resident interests.</p> <p>The November 2013 activity calendar documented for Monday through Friday ranged from 1 to 4 activities scheduled each day and only 6 out of the 21 weekdays had an activity scheduled after 2:15 PM. On Saturday and Sunday there was one activity scheduled for each of these days, along with "Friends and Family" listed on Sundays without a time.</p> <p>The December 2013 activity calendar documented for Monday through Friday ranged from 1 to 4 activities scheduled each day and only 5 out of the 22 weekdays had an activity scheduled after 2:15 PM. On Saturday and Sunday there was one activity scheduled for each of these days, along with "Friends and Family" listed without a time. On 12/25/13 there was only "Friends and Family" listed without a time.</p> <p>The January 2014 activity calendar documented for Monday through Friday ranged from 1 to 4 activities scheduled each day and only 3 out of the 23 weekdays had an activity scheduled after 2:30 PM. On Saturday and Sunday there was one activity scheduled for each of these days, along with "Friends and Family" listed without a time.</p> <p>The February 2014 activity calendar documented</p>	F 248	<p>F248</p> <p>Resident Specific No specific resident identified</p> <p>Other Residents The ID team reviewed interview able residents for psychological harm or negative behaviors related to boredom. Adjustments have been made as indicated.</p> <p>Facility Systems Activity staff educated to needs of residents as it relates to activities for residents. Activity calendar was modified to ensure provision of activities to meet the interests of current resident at times to include evening and weekend activities. Re-education was provided to include but not limited to, varies activities to be provided for residents during evening and weekend hours, adjust hours to provide activities during late afternoon.</p>	4-3-14

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F 248 Continued From page 11

for Sunday through Saturday ranged from 1 to 4 activities scheduled each day and only 8 out of the 28 days had an activity scheduled after 2:30 PM.

During the resident Group interview on 2/25/14 at 10:45 AM, residents were asked about the facility's activity program. Four of the 6 residents in attendance said they wanted more activities, especially in the evenings and on the weekends. They also said the activity program had declined over the past three months with not enough staff to assist residents with activities. One resident in the group stated of the activities, "I wouldn't sleep so much if there more "

On 2/27/14 at 8:50 AM, the Activity Director was interviewed regarding the activity issues. When asked about the lack of activities in the late afternoons and evenings, she said they did occasionally conduct random smaller group activities which were not listed on the calendar. When asked what the activity "Friends and Family" was, she stated it was, "Just people coming in," visiting their family or friends who reside in the facility. When asked why there was normally only one activity scheduled on weekend days, she stated, "I guess we need to schedule more." She also stated, "I wish we could have more [activities], we could offer more." When asked to clarify this statement, she said, she had asked for more hours for activities staff, but was told to use more volunteers instead. When asked who set the activities budget, she stated, "Corporate sets the activity hours."

On 2/27/14 at 9:15 AM, the Administrator was interviewed about the activities budget. She said the activity budget was set by the corporation with

F 248

Monitor

The ED or designee will review activity calendar monthly, attend quarterly resident council meeting to follow up on resident concerns with activities, ADHOC person to attend one resident council meeting per quarter for discussion about activity programs without activity staff, will audit 3 residents for adequate activities weekly for 8 weeks. The review will be documented on the PI audit tool, starting 4/3/14. Any concerns will be addressed immediately and identified trends discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.

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F 248	<p>Continued From page 12</p> <p>some input from the administrator, but she stated it. "Comes down to whatever corporate decides."</p> <p>On 2/27/14 at 4:05 PM the Administrator, DNS, and DDCO were informed of the issue. No further information was provided by the facility.</p> <p>F 252 483.15(h)(1) SS=B SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure a clean, comfortable, and homelike environment. This was true for 13 of 51 (Room #'s 101, 102, 104, 106, 108, 201, 204, 208, 212, 214, 307, 315, and 320) resident rooms. Findings included:</p> <p>On 2/27/14 from 8:15 to 8:25 AM the following rooms were observed to have cracks in the vinyl flooring: *Room 101- had (5) 1 foot by 1/4 inch cracks just inside the door way, in the middle of the room, and next to the bathroom door, *Room 102- had a 3 inch and a 6 inch spider web crack next to bed A and a 2 inch spider web crack in the middle of the room, *Room 104- had (2) 1 foot long spider web cracks just inside the door and next to the bathroom door. *Room 106- had (2) approximately 1 inch by 1</p>	F 248	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Lewiston Rehabilitation & Care Center 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 252

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F 252	<p>Continued From page 13</p> <p>inch pieces of vinyl missing and a 5 foot by 1/4 inch crack in the middle of the room; *Room 108- had a 2 foot by 1/4 inch crack and a 1 foot long spider web crack in the middle of the room; *Room 201- had (2) 1 foot by 1/4 inch cracks just inside the door way. *Room 204- had a 1 foot by 1/4 inch crack just inside the door way; *Room 208- had (2) 3 inch by 3 inch spider web cracks a few feet from the door way; *Room 212- had (2) 6 inch by 6 inch spider web cracks just inside the door way; *Room 214- had (4) 1 foot by 1 foot spider web cracks just inside the door way; *Room 307- had a 3 foot by 1/4 inch crack and a 6 inch by 3 inch spider web crack just inside the door way. *Room 315- had (3) 3 foot by 1/4 inch cracks a few feet from the door way; and *Room 320- had a 2 foot long spider web crack just inside the door.</p> <p>On 2/27/14 at 10:00 AM the Maintenance Supervisor was informed of the cracks in the flooring and he said he was aware of the issue and he was working on replacing the floors. He provided the surveyor a copy of a capital improvement request he submitted on 2/14/14 to the facility's Regional Vice President which documented, "Replace flooring in all resident rooms/bathrooms..."</p> <p>On 2/27/14 at 4:05 PM the Administrator, DNS, and DDCO were informed of the issue. No further information was provided by the facility.</p>	F 252	<p>F252</p> <p style="text-align: right;">4-3-14</p> <p>Resident Specific Vendor has been secured and contracted to install new floors in rooms 101, 102, 104, 106, 108, 201, 204, 208, 212, 214, 307, 315, and 320</p> <p>Other Residents The ID team reviewed other resident rooms for need of floor replacement and added to list of rooms for replacement.</p> <p>Facility Systems Facility staff is educated to report areas needed repair to maintenance department for repair. Re-education was provided to include but not limited to, how to report areas of concern needing repair.</p> <p>Monitor The Maintenance manager or designee will audit 5 rooms for any areas need of repair weekly for 8 weeks. Then monthly on environmental rounds and report given to ED/regional maintenance personnel. The review will be documented on the PI audit tool, starting 4/3/14. Any concerns will be addressed immediately and identified trends discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p>	
F 280 SS=D	483 20(d)(3), 483 10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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F 280	<p>Continued From page 14</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, record review, and staff and resident interview, it was determined the facility failed to revise the care plan of a resident who refused to wear physician ordered boots as part of a pressure ulcer prevention plan. This was true for 1 of 13 (#3) sampled residents. This created the potential for harm if the resident did not receive appropriate care related to pressure ulcer prevention. Findings included:</p> <p>Resident #3 was admitted to the facility on 11/14/13, and readmitted on 1/7/14, with multiple diagnoses which included unspecified renal failure, anemia and osteoporosis</p>	F 280	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Lewiston Rehabilitation & Care Center 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>F280</p> <p>Resident Specific The ID team reviewed resident #3. Care plan revised to show float heels while in bed.</p> <p>Other Residents The ID team reviewed other residents care planned for care boots for appropriateness of use and accuracy on care plan. Adjustments have been made as indicated.</p> <p>Facility Systems Licensed Nurses and Certified Nursing Assistance are educated to care plan updates. Re-education was provided to include but not limited to, refusal of current plan of care and how to adapt plan of care to meet the needs of the residents.</p>	4-3-14

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F 280 Continued From page 15

The annual MDS assessment for Resident #3, dated 11/21/13, documented in part:
 * Intact cognition with BIMS score of 14.
 * Extensive assistance needed with 2 or more people for transfers.
 * Extensive assistance needed with 1 person for bed mobility and dressing.
 * Range of motion impairment on both lower extremities, and,
 * At risk for development of pressure ulcers.

Resident #3's Care Plan documented in part:
 * Focus - "[Resident's name] has actual impairment to skin integrity r/t [related to] Actual impairment to Left lower extremity, wound" dated 11/14/13 with a revision on 2/19/14; and,
 * Interventions - "[Resident's name] to have care boots on at all times while in bed" with an initiation date of 11/16/13 and revision on 11/26/13, and "Float Heels when in bed" initiated on 12/3/13.

On 2/25/14 at 11:30 a.m. Resident #2 was asked if she was wearing boots on her feet at which she stated, "No" and added she did not wear boots while in bed. The left foot was observed to be bare with Kerlix wrapped from below the knee to the underside of the foot covering the heel. A blue non-skid sock was observed on the right foot.

On 2/25/14 at 1:46 p.m. CNA #1 and CNA #2 were observed as they gave Resident #3 a boost in bed and placed pillows underneath both hips. CNA #2 was asked if the resident was to wear boots on her feet while in bed. The CNA stated, "She has wraps, not boots" and added the staff would float her heels with a pillow but the resident would sometimes kick it out. Resident #3

F 280 **Monitor**

The DNS or designee will audit 5 care plans weekly for accuracy in interventions for prevention of pressure ulcer for 4 weeks then 3 care plans weekly for 8 weeks. The review will be documented on the PI audit tool, starting 4/3/14. Any concerns will be addressed immediately and identified trends discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.

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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 280	Continued From page 16 declined observation of her feet to note if her heels were floated On 2/26/14 at 2:30 p.m., LN #3 was asked if Resident #3 was to wear care boots while in bed. The LN stated, "Probably did at one point. She didn't like them on," and added they "Did float heels with pillows instead." At 2:55 p.m., LN #3 was asked if there were documented refusals to wear the care boots by Resident #3. The LN said yes and provided an ADL flowsheet which documented staff initials with circles for the instruction of, "[Resident's name] to have care boots on at all times while in bed." The LN said the circled initials indicated the resident refused. When asked if the care boots should still be on the care plan for Resident #3, the LN stated, "No, I'll take care of that." On 2/26/14 at 6:05 p.m., the Administrator and DON were informed of the care plan issue. However, no further information or documentation was provided.	F 280	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Lewiston Rehabilitation & Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings,
F 309 SS=D	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 by: Based on observation, resident and staff	F 309	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.

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

PRINTED: 03/10/2014
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F 309	Continued From page 17 interview, and record review it was determined the facility did not re-evaluate the pain management regimen for a resident with consistent complaints of pain. This was true for 1 of 8 residents (Resident #1) sampled for pain control. The deficient practice had the potential to cause more than minimal harm when a resident experienced pain impacting her sleep. Findings included Resident #1 was admitted to the facility on 10/24/13 with multiple diagnoses which included left hip fracture, chronic ischemic heart disease and hypertension Resident #1's most recent Quarterly MDS, dated 12/19/13, coded: *Moderately impaired cognitive skills; *Pain present, requiring routine, as needed and non-medication interventions; and *Pain is frequent, with an intensity of an 8 [on a scale of 0 to 10], impacting sleep. Resident # 1's Physician's Orders [Recapitulation Orders] for February 2014 documented, for pain control. *Duragesic patch, 12 mcg, changed every 3 days *Acetaminophen 325 mg, 2 tablets as needed three times daily, for a pain level of 1 to 4 *Hydrocodone 10 mg/Acetaminophen 325 mg [Norco] 1 tablet every 4 to 6 hours as needed for a pain level of 5 to 10. *There was also an order for an 81 mg aspirin tablet daily for CVA/MI prevention *The resident also had an order for Restoril 15 mg as needed at bedtime for insomnia The resident's MAR for January 2014	F 309	F309 Resident Specific The ID team reviewed resident #1 Medication reviewed with MD hypnotic was discontinued and pain medication scheduled at hours sleep Other Residents The ID team reviewed other residents for use of as needed medication use and effectiveness, including pain management. Adjustments have been made as indicated. Facility Systems Licensed Nurses are educated to indication for use of as needed medication. Re-education was provided to include but not limited to, indications for as needed sleep medication, use of as needed pain medication, and assessment of pain management, indication for pursuing pain regimen change for residents with increase usage of as needed pain medication Monitor The DNS or designee will audit 3 residents for as needed hypnotic medication use weekly for 8 weeks. The review will be documented on the PI audit tool, starting 4/3/14. Any concerns will be addressed immediately and identified trends discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.	4-3-14	

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F 309 Continued From page 18

documented the resident received "as needed" Norco on the 3 PM to 11 PM shift 29 of 31 days. The MAR for February documented the resident received "as needed" Norco 21 of 25 days for the same shift

On 2/25/14 at 10:30 AM, the resident was interviewed regarding her quality of life in the facility. The resident, who was resting in bed at the time of the interview, stated she sometimes preferred to stay in bed because, "I'm 100 years old, and sometimes my leg hurts." The resident further stated there were times, particularly, "as the day wears on when it's just more comfortable to stay in bed because that darned leg starts giving me trouble."

On 2/26/14 at 11:35 AM, the DNS was asked about Resident #1's pain, and her use of pain medication frequently on the evening shift. The DNS stated she would have to review the resident's pain flow sheets and usage of pain medication.

On 2/27/14 at 9:50 AM, the DNS stated she had reviewed the resident's pain tracking and medication use, and there seemed to be a pattern of the resident using her pain medication fairly routinely on the evening shift. The DNS stated the facility had not recognized that pattern before, but after their review they had faxed the MD to see if the resident might benefit from more routine pain control in the evening.

On 2/27/14 at 4:15 PM, the Administrator, DNS, and DDCO were informed of the surveyor's findings. The facility offered no further information.

F 309

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

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F 309 F 314 SS=G	<p>Continued From page 19</p> <p>NOTE: Please see F 329 as it pertains to the use of psychotropic medications without clear indications for use.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable, and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews, it was determined the facility caused harm when the facility failed to: * Promote healing of a Stage II pressure ulcer, on a resident's coccyx, that deteriorated to an "unstageable" pressure ulcer. * Prevent a Stage II pressure ulcer from developing on the resident's right ankle; and * Monitor and evaluate the effectiveness of interventions on the care plan and revise those interventions as appropriate. This was true for 1 of 7 (#4) residents sampled for skin breakdown. Findings include: Resident #4 was admitted to the facility with multiple diagnoses including, COPD, diabetes mellitus type II, mild dementia, malnutrition with hypoalbuminemia (low protein), right-sided pneumonia, and a mass in the right, upper lung.</p>	F 309 F 314	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Lewiston Rehabilitation & Care Center 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>Resident Specific The ID team reviewed resident #4 Resident was discharged from facility on 2/27/14</p> <p>Other Residents Clinical management team and licensed nurses completed resident skin assessments. Assessments were reviewed and no new pressure ulcers were identified</p> <p>Facility Systems Licensed Nurses are educated to prevention of pressure ulcers and healing of skin injuries. Re-education was provided to include but not limited to, healing of wounds versus none healing, preventive measures of developing pressure ulcers, and MD notification of status of wound.</p>	

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F 314	Continued From page 20 NOTE: Interpretive Guidance for F314 states that current literature documents, "If a pressure ulcer fails to show some evidence of progress toward healing within 2-4 weeks, the pressure ulcer (including potential complications) and the resident's overall clinical condition should be reassessed. Re-evaluation of the treatment plan including determining whether to continue or modify the current interventions is also indicated... The clinicians, if deciding to retain the current regimen, should document the rationale to continuing the present treatment (for example, why some or all, of the plan's interventions remain relevant despite little or no apparent healing." The resident's Admission MDS, dated 12/26/13, coded in part: * Severely impaired cognition, with a BIMS score of 10; * Extensive assistance of 1 person for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing; * At risk for pressure ulcers (PU); * One unhealed stage II PU, present on admission; and * No other ulcers, wounds, or skin problems present on admission; * Epithelial tissue present indicative of, "New skin growing in superficial ulcer." The resident's Care Area Assessment (CAA), dated 12/31/13, documented, "Rsd (Resident) was admitted with a stage 2 on coccyx which has resolved." The following was documented, under provide input from resident and/or family/representative regarding this care area, "Rsd (Resident) and family are aware of care	F 314	Monitor The DNS/WCC nurse or designee will Review the following: Weekly skin checks completed by the licensed nurse for new pressure ulcers and/or skin issues. If new issues arise DNS, WCC or designee will validate that wound assessment is completed, physician notified for treatment orders, and the plan of care is updated to address root-cause and prevention of further skin issues. Four residents will be reviewed weekly for 4 weeks, then 2 residents weekly for 4 weeks. Residents in clinical management team meeting for a change of condition, change in Braden score and/or new admission. If a change occurs, DNS, WCC or designee will assess risk factors and update the plan of care for prevention of pressure ulcers as indicated. Residents that trigger a change will be reviewed daily and plan updated Residents with current wounds for overall health decline and/or wound healing, physician will be notified if the wound lacks indications of healing after 2 weeks: physician directives will be documented and followed, with plan of care update. Resident with current wounds will be reviewed weekly.		

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

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F 314	<p>Continued From page 21 needs and have no concerns at this time. Pleased at [sic] PU has healed."</p> <p>NOTE: The above CAA documented on 12/31/14, "Stage 2 [pressure ulcer] on coccyx resolved;" however, the resident's weekly skin check dated 1/2/14 documented, "Coccyx - Stage II open area, 2.0 x 0.2 x 1." On 2/27/14, at 2:15 PM, the DNS was interviewed related to discrepancy between the CAA and the weekly skin check form. The DNS said she was unsure why the CAA documented the pressure ulcer was healed and confirmed the pressure ulcer was still present and had not resolved.</p> <p>NOTE: For reading purposes, the following - pressure ulcer wound measurements below are: length x width x depth and are measured in centimeters.</p> <p>The resident's Nursing Admission Assessment, dated 12/19/13, documented, "Pressure Ulcer present to coccyx measuring 1 cm x 0.1 cm x 0.01 cm open area (slit), surrounding skin pink/blanchable (4 x 4 x 0), foam bordered drsg [dressing] in place upon admit, heels firm..."</p> <p>The resident's Nursing Admission Assessment, Bates-Jensen Wound Assessment Tool (BWAT), Progress Notes (PM), Pressure Ulcer Investigation Report, and Weekly Skin Checks (WSC) documented the following:</p> <p>*12/19/13, BWAT & WSC - Coccyx, stage II, measuring 1 x 0.1 x 0.1, monitor and apply foam bordered dressing, change every 3 days and prn. *12/23/13, BWAT - Coccyx, stage II, measuring 1 x 0.2 x 0, continue current treatment. *12/26/13, WSC - Coccyx, stage II, measuring</p>	F 314	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Lewiston Rehabilitation & Care Center 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>Residents with ongoing non-healing wounds will request referred for evaluation by the primary physician and/or a physician with wound care specialty as indicated.</p> <p>Residents with non-compliance for skin prevention (use of devices and turning) will be educated with risks and benefits documented. Alternative plans will be explored and document in an attempt to gain resident compliance. Clinical rounds by the licensed nurse will validate implementation of skin prevention plans and compliance. DNS, WCC and /or designee will complete clinical rounds three times weekly to validate consistent implementation of plans to prevent pressure ulcers and promote wound healing. Additional measures for prevention and /or healing will be implemented as indicated and plans of care updated as indicated.</p> <p>Audits will start the week of April 3, 2014 documentation will take place on the audit</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	<p>Continued From page 22</p> <p>1.0 x 0.2 x 0, continue with foam border dressing to coccyx, change every 3 days and prn...</p> <p>*12/30/13, BWAT - Coccyx, stage II, measuring 1.5 x 0.5 x 0, continue current treatment;</p> <p>*1/2/14, WSC - Coccyx, stage II 2.0 x 0.2 x 0.1, border foam dressing in place, change every 3 days and prn.</p> <p>*1/6/14, BWAT - Coccyx, stage II, measuring 2 x 3 x 0, continue current treatment;</p> <p>*1/9/14, WSC - "Ulcer care for coccyx continues..."</p> <p>*1/13/14, BWAT - Coccyx, unstageable, measuring 2 x 3 x 0, "New development of slough in wound bed, treatment order change requested from MD. Rsdrt [Resident] is also comfort measures with likely metastatic malignancy which family is choosing to not aggressively treat. She is on dietary supplements, turning program, air mattress, and roho cushion."</p> <p>*1/16/14, WSC - "Continues with ulcer to coccyx..."</p> <p>*1/20/14, BWAT - Coccyx, unstageable, measuring 2.5 x 3.5 x 0, "Treatment changed last week, currently wound is stable from prior assessment. Rsdrt is comfort care with metastatic lung cancer. All care plan interventions in place for skin." NOTE: The BWAT documents the wound was "stable;" however, the length and width of the wound had increased in size, in one week, from 2 x 3 x 0 to 2.5 x 3.5 x 0 and from 1 x 0.1 x 0.1 to 2.5 x 3.5 x 0 in 4 weeks.</p> <p>*1/23/14, WSC - "...Coccyx treatment continues."</p> <p>*1/27/14, BWAT - Coccyx, unstageable, measuring 2.5 x 3.5 x 0, continue current tx.</p> <p>*1/30/14, WSC - "Continues with ulcer cares..."</p> <p>*1/30/14, BWAT - "Coccyx, unstageable, measuring 2.5 x 2.5 x 0.5. Wound continues to deteriorate, "Covered in slough but appears to be deepening. Mattressing [sic] being upgraded to</p>	F 314	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Lewiston Rehabilitation & Care Center 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>tool. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee</p> <p>may adjust the frequency of monitoring after 8 weeks as it deems appropriate.</p>	<p>4/13/14</p>

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F 314	Continued From page 23 low air loss air mattress. Will also request order change from MD *2/2/14, PN - "Coccyx wound not improving, appears to have more slough and increasing depth. Unable to visualize wound bed due to yellow slough, but is obviously not attached to wound edges. Draining moderate amount of serous drng (drainage). Mattressing being upgraded to low air loss air mattress " * 2/10/14, BWAT, - Coccyx, unstageable, measuring 3 x 2.5 x 1 "Treatment changed to medihoney with foam dressing last week. Slough has become less attached and starting to autolytically debride [sic]. Overall measurements, besides depth, have decreased, however undermining is now present along all wound margins " * 2/13/14, Weekly Skin Check (WSC), - "Skin is pale in color, continue treatment to ulcer on coccyx. " * 2/15/14, PN - "This afternoon while giving cares the CNA noted a sore to the Right outer ankle that was dry and scabbed over. The area shows no s/s infection. Area cleaned and dressed. Wound nurse to assess on Monday." "A facility provided document, "Pressure Ulcer Investigation," dated 2/15/14, documented the following, "Stage II pressure ulcer to the right lateral malleolus, measuring 0.5 x 0.5 x 0. Pressure Ulcer to right outer ankle bone noted when CNA removed socks at 11:30 AM. Area is several days old and scabbed. Rsdrt has been sleeping in bed with her care boots on. Area cleansed and dressed." "When daughter was notified she stated its been there for about 1.5 weeks [and the daughter noticed it] when she had been lotioning her [Resident #4's] feet. I (RN #5) observed her feet on Feb[ruary] 2nd and it wasn't there." NOTE: The resident's Electronic Medical	F 314		

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

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F 314	<p>Continued From page 24</p> <p>Record (EMR) and paper medical record, did not include any evidence of weekly skin checks (a total body assessment) between 1/30/14 and 2/13/14.</p> <p>*2/17/14, BWAT, - Coccyx, unstageable, measuring 4 x 2.5 x 1. "Wound continues to deteriorate. Currently using medi-honey with alginate and bordered foam. Will notify MD to see if any other tx (treatment) options may be indicated."</p> <p>*2/20/14, WSC, - Right ankle, stage II ulcer, see BWAT report. Ulcers to coccyx and Rt (right) outer ankle noted, see BWAT report...</p> <p>*2/24/14, BWAT, - Coccyx, unstageable, measuring 5 x 3 x 1X. "Current tx (treatment) is medihoney with bordered foam q (every) day. See care plan for additional interventions." Additionally, documented on the BWAT for this day was, "Right ankle (outer), stage II, measuring 0.5 x 0.5 x 0. Continue bordered foam drsg (dressing) "</p> <p>The following was observed related to Resident #4's positioning</p> <p>*2/25/14, 8:10 AM to 10:15 AM, 1:45 PM to 3:45 PM, resident lying in bed on her back, with heel boots on</p> <p>*2/26/14, 1:10 PM to 3:10 PM, resident lying in her bed on her back/ right side, with heel boots on</p> <p>On 2/26/14 at 3:40 PM, the wound nurse, DNS, and surveyor observed the resident's pressure ulcer to her buttocks and right ankle. The wound nurse measured each wound, listed below are the measurements.</p> <p>* Coccyx pressure ulcer - 5.5 x 3.5 x 1.5, "New eschar present at the superior/inferior edges. Undermining = 100 percent all the way around</p>	F 314		

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

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F 314 Continued From page 25
the wound and has a depth of 0.5 cm to 3.0 cm. The pen-wound is red/blanches, zero swelling and zero induration."
* Right lateral ankle pressure ulcer - measured "0.5 x 0.9 x 0, and is unstageable."

* 2/27/14, 8:30 AM to 10:00 AM, resident lying on her back/ right side, with heel boots on

The resident's Care Plan, dated 12/19/13 included the following:
* Avoid scratching and keep hands and body parts from excessive moisture.
* [Resident #4] needs pressure relieving/reducing mattress to protect the skin while up in chair and up in bed.
* Turn and reposition every 2 hours when in bed.
* Float heels when in bed, use heel lift boots or pillows (revised 1/22/14).
* Skin inspection every week, observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse
* Assess/record/monitor wound healing every week. Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed, and healing progress. Report improvements and declines to MD.

The facility failed to modify, change existing interventions, and/or add additional interventions when the resident's condition changed. For example, modifying, reposition every 2 hours and pm to reposition every hour, assist resident to off load pressure to buttocks when up in wheelchair; modify the head of bed or the back of the reclining chair to an angle of 30 degrees or less to decrease the amount of pressure exerted on the sacrum and coccyx, and utilizing dynamic pressure reduction surfaces if not clinically

F 314

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

PRINTED: 03/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/28/2014
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - LEWISTON		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501	
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			(X5) COMPLETION DATE

F 314 Continued From page 26

contraindicated. In addition, the facility failed to ensure documentation of weekly skin inspections

During an interview with a family member regarding the resident's care on 2/27/14 at 1:45 PM, the surveyor was provided with the following information. The family member knew the resident was admitted with a "small opening" to her buttocks and the opening had gotten worse over time. The family member stated she would like [Physician's name] to look at the resident's pressure ulcer and she [the family member] would talk to the resident about it. The family member stated the resident did not want aggressive treatment for the cancer, but had never said she [the resident] did not want treatment related to "bed sores."

On 2/27/14, at 2:15 PM, the DNS and wound nurse were interviewed related to the above concerns. The surveyor asked the DNS about the resident's bed. The resident started on a pressure relieving facility mattress on 12/19/13, changed to a facility air mattress overlay on 1/13/14, and "upgraded" to a low air loss bed on 2/3/14. The DNS stated, when a resident at high risk for developing pressure ulcers, is admitted to the facility, the facility ensures the resident receives a pressure reducing mattress for his/her bed. The surveyor asked why the facility waited until the wound had deteriorated to implement the air bed overlay and then the low air loss bed. The DNS stated, "Low air loss beds are slippery and they are more expensive." The wound nurse added, "We don't get out the big guns (Cadillac bed) until the resident really needs it." The surveyor asked how does the staff know when revisions had been made to the care plan. The DNS and wound nurse stated there would be an initiated date

F 314

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

PRINTED: 03/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/28/2014
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F-314	<p>Continued From page 27</p> <p>followed by a revision date and/or deleted/resolved date. The wound nurse stated the facility had not, "deleted or resolved" anything related to interventions on the resident's skin care plan. No further information was provided at the time to resolve the issue.</p> <p>On 3/3/14 the Bureau of Facility Standards received additional information from the facility for review.</p> <p>The resident's [Local Hospital] Admission note, dated 2/27/14, documented, "...After an independent reviewer did look at the decubitus [ulcer] and discussed with this particular [family member]. She [the resident] was sent down to the ER where she was noted to have UTI, hypotension and likely sepsis with a high white count and also her decubitus was noted to be quite substantial and quite deep with the decubitus likely, I believe, going down to bone. I believe I could palpate bone when I palpated the decubitus. She has an ankle with a small pressure sore with a small rim of surrounding erythema..."</p> <p>The additional information provided by the facility did not resolve concerns related to the resident's pressure ulcers.</p> <p>The resident was harmed when the facility failed to identify changes in the resident's condition which required additional or different interventions and to validate the effectiveness of current interventions. This resulted in "A stage II coccyx pressure ulcer that was present on admission deteriorating to an "unstageable" pressure ulcer that was noted to be, "quite substantial and quite deep, going down</p>	F-314		

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

PRINTED: 03/10/2014
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - LEWISTON	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501
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F 314 Continued From page 28
to bone" and resulted in a hospital admission, and
"The development of stage II pressure on her
right ankle
F 315 483 25(d) NO CATHETER, PREVENT UTI,
SS=D RESTORE BLADDER

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by
Based on observation, staff interview, policy review and record review, it was determined 1 of 5 sampled residents (#2) reviewed for incontinence care did not have an incontinence care plan after a Foley catheter was removed. This had the potential to harm the resident if the resident had a urinary decline or developed UTI's (urinary tract infection) due to insufficient incontinence care. Also, the facility failed to ensure a resident who was admitted to the facility with an indwelling catheter received the appropriate care and services to prevent infections. This affected 1 of 3 residents (#10) reviewed for indwelling catheters. This had the potential to harm the resident if the resident's lack of appropriate catheter care caused the development of a UTI or other complications.

F 314 This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Lewiston Rehabilitation & Care Center 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.

F315

Resident Specific

The ID team reviewed resident #2 and #10
Resident #2 plan of care updated with bladder training/toileting program
Resident #10 CNA flow sheets updated with Foley catheter care every shift and as needed and care plan updated

Other Residents

The ID team reviewed other residents for appropriate Foley catheter care and/or recent removal of Foley catheter and bladder status. Care plans updated as indicated.

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

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OMB NO. 0938-0391

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F 315	<p>Continued From page 29</p> <p>1 Resident #2 was admitted to the facility on 9/12/13 with multiple diagnoses including osteoporosis, and pressure ulcers</p> <p>The facility's Policies and Procedures, Indwelling Catheters included in part</p> <p>" 5 After removal of indwelling urinary catheter, the patient is assessed for</p> <p>... a. Spontaneous voiding, and</p> <p>... c. Individualize bladder rehabilitation and/or training program to restore or improve bladder function, which may include prompting, habit training and/or toileting every two hours.. "</p> <p>The resident's Quarterly MDS assessment dated 12/19/13, documented the resident.</p> <ul style="list-style-type: none"> -was cognitively intact with a BIMS of 15; -required extensive assistance with bed mobility and toilet use; and -had an indwelling urinary catheter. <p>The resident's CNA Flow Sheet Record documented</p> <ul style="list-style-type: none"> -From 9/12/13 to 1/26/14 foley care was provided every shift, and -For February 2014 the resident was incontinent of bladder every day for all shifts. <p>NOTE: The resident's entire care plan was reviewed but it did not address incontinence issues</p> <p>On 2/26/14 at 4:10 PM, the DNS was interviewed regarding resident's care plan and bladder retraining programs. The DNS said, "I don't see an intervention there for bladder retraining. She is dependent. I agree, I don't see any interventions. I don't see where it has been fully discussed or brought up."</p>	F 315	<p>Facility Systems</p> <p>Licensed Nurses and Certified Nursing Assistants are educated to effects of indwelling catheters and bladder status as well as care of resident with indwelling catheters. Re-education was provided to include but not limited to, bladder re-training after use of indwelling catheters and prevention of urinary tract infections and care of indwelling catheters.</p> <p>Monitor</p> <p>The DNS/SDC or designee will audit 2 residents with Foley Catheter and/or resident with recent removal of Foley Catheter for documentation of care of indwelling catheter and/or need for bladder training for resident after removal of catheter and update care plan as needed weekly for 8 weeks. The review will be documented on the PI audit tool, starting 4/3/13. Any concerns will be addressed immediately and identified trends discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p> <p style="text-align: right;">4-3-14</p>

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

PRINTED: 03/10/2014
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - LEWISTON	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501
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F 315 Continued From page 30

F 315

2. Resident #10 was re-admitted on 2/11/14, with multiple diagnoses including chronic UTI's, pressure ulcers, and functional decline.

The facility's Policies and Procedures, Indwelling Catheters includes in part

. 9. Infection control is followed in the care of indwelling catheters. Guidelines to prevent Catheter Associated Infections (CAUTI),

. h. Good hygiene is maintained at the catheter-urethral interface cleaned daily with soap and water.

. 10. The care plan reflects.

. b. Intervention to reduce or prevent urinary tract infections "

The resident's Significant Change MDS assessment dated 2/20/14, documented the resident

-had an indwelling catheter.

Resident #10's Care Plan included a focus area documented on 11/27/12. "[Resident] had bowel incontinence r/t [related to] DX [diagnosis] of Ulcerative Colitis " The goals documented included, "[Resident] will be continent during daytime through the review date "

Interventions included in part:

-"Provide pericare am/pm [and] after each incontinent episode "

The resident's Care Plan included a focus area revised on 2/11/14. "[Resident] has an Indwelling Catheter." Goals documented included:

"[Resident] will not develop any complications associated with catheter use through next review date." Interventions included in part:

"CATHETER: [Resident] has 16 French 10cc

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

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--	--	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - LEWISTON	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501
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F 315	<p>Continued From page 31</p> <p>[cubic centimeter] balloon catheter. Position catheter bag and tubing below the level of the bladder and away from entrance room door [sic].</p> <ul style="list-style-type: none"> -Change catheter per policy / physician order; -Check tubing for kinks each shift. -Keep drainage bag below level of bladder and maintain in privacy bag, and -Monitor/record/report [sic] to MD [Medical Doctor] for s/sx [signs and symptoms] UTI, pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns " <p>NOTE. There were no interventions on the care plan to address the prevention or reduction of UTI's for the resident. The interpretive guidance at F315 states that the facility should, "...Identifies approaches to minimize risk of infection (personal hygiene measures and catheter/tubing/bag care)."</p> <p>NOTE. The resident's CNA Flow Sheet Record or Treatment Record did not document Foley care performed for the month of February. The interpretive guidance at F315 documented, "Because the major factors (other than an indwelling catheter) that predispose individuals to bacteriuria, including physiological aging changes and chronic comorbid illnesses, cannot be modified readily, the facility should demonstrate that they employ standard infection control practices in managing catheters and associated drainage system, defined and implemented pertinent interventions to try to minimize complications from an indwelling urinary catheter."</p> <p>On 2/27/14 at 9:30 AM, the nurse consultant and</p>	F 315		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO 0938-0391

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--	--	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - LEWISTON	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501
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F 315	Continued From page 32 SDC (Staff Development Coordinator) were interviewed and asked where the catheter care was documented. They looked through the CNA flowsheets for approximately five minutes and the nurse consultant said, "We don't have to document it [foley care]. It's just part of her care." When asked how they ensure foley care is done for this resident, the SDC said, "They see her foley catheter so they would know to do her cares. It is just part of her care when she has a foley, so we just do it as part of her cares."	F 315		
	On 2/27/14 at 4 00 PM, the Executive Director, DNS and Nurse Consultant were notified of concerns. No further information was received regarding this issue.			

F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by Based on observation and staff interview, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as possible when equipment not in use was parked in the hallways blocking handrails. This was true for residents who used the A and B hallways for independent mobility. This failure created the potential for more than	F 323		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 33</p> <p>minimal harm should residents slip, trip and fall and not have access to handrails. Findings included</p> <p>On 2/25/14 the following observations were made of equipment not in use in the A hallway:</p> <ul style="list-style-type: none"> * 9:10 a.m., a linen cart was parked outside of room 105, a janitor cleaning cart was on the other side of room 105, and a Hoyer lift and sit-to-stand lift were parked outside of room 107. Directly across the hall between rooms 102 and 104, a brown cardboard box with several small colored boxes in it and a "Caution Wet Floor" sign were on the floor in the hallway. All items blocked access to handrails; * 9:30 a.m., the aforementioned Hoyer lift was parked between rooms 100 and 101 which blocked the handrail. The linen cart, sit-to-stand lift, cardboard box and "Caution Wet Floor" sign were still in the same locations as previously documented; * 10:00 a.m., the linen cart was parked outside of room 103 and the Hoyer lift was parked outside of room 100 which blocked the handrail; * 11:27 a.m., a Hoyer lift was parked outside of room 100 which blocked the handrail; * 12:00 p.m., the Hoyer lift was parked outside of room 101 which blocked access to the handrail; and, * 1:45 p.m., a trash cart and linen cart was parked outside of room 101 which blocked the handrail. The carts were observed in the same location at 3:30 p.m. <p>On 2/25/14 the following observations were made of equipment not in use in the B hallway:</p> <ul style="list-style-type: none"> * 9:43 a.m., a trash cart and linen cart were parked outside of room 208 which blocked the handrail; 	F 323	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Lewiston Rehabilitation & Care Center 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>	4-3-14

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

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OMB NO. 0938-0391

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F 323	<p>Continued From page 34</p> <p>* 9:51 a.m., the trash and linen carts were observed in the same location, outside of room 208, as a resident ambulated with Physical Therapy down the hallway. The resident used the handrail while the Physical Therapist held onto a gait belt around the resident's waist. The linen and trash carts were observed in the same location at 10:00 a.m.;</p> <p>* 11:26 a.m., the trash and linen carts were parked outside of room 204 which blocked the handrails. The carts were observed in the same location at 11:40 a.m., and,</p> <p>* 3:30 p.m., the trash and linen carts were observed in the same location parked outside of room 204 which continued to block access to the handrail.</p> <p>On 2/28/14 at 11:06 a.m., a sit-to-stand lift was parked outside of room 107 which blocked the handrail. A Hoyer lift was parked outside of room 109 which blocked access to the handrail.</p> <p>On 2/26/14 at 3:06 p.m., CNA #4 was interviewed about the linen and trash carts observed in the hallways. She said they, "Move them every 15 minutes" and will move the carts out of the way for the meal cart. The CNA said the carts are usually in the hall for the main part of the day and the linen carts were for dirty linen which would be taken to the dirty linen room at the end of the shift or as needed. When asked where equipment was stored such as Hoyer lifts, the CNA said they would keep the lifts in a resident's room if the resident was up, or they would put the equipment on one side of the hall. When asked if there was a storage room for equipment the CNA stated, "I don't believe we have a storage room for Hoyers and sit-to-stands."</p>	F 323	<p>F323</p> <p>Resident Specific Halls A and B cleared of obstruction to handrails</p> <p>Other Residents The ID team reviewed other halls for obstruction to handrails. Adjustments have been made as indicated.</p> <p>Facility Systems Facility staff is educated related to safety for need of residents to be able to access handrails. Re-education was provided to include but not limited to, areas designated for equipment storage.</p> <p>Monitor The ED or designee will audit halls A, B and C for obstruction to handrails 3 times a week for 3 weeks then weekly for 5 weeks. The review will be documented on the PI audit tool, starting 4/3/14. Any concerns will be addressed immediately and identified trends discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p>	4-3-14

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

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F 323	Continued From page 35 On 2/26/14 at 6:00 p.m., a copy of the Policy and Procedure for equipment storage was requested to the Administrator and DON. However, a Policy and Procedure was not provided. On 2/27/14 at 10:32 a.m., a soiled linen cart and trash cart were observed parked between rooms 202 and 204 which blocked the handrail. At 11:45 a.m. the dirty linen and trash carts were in the same location as well as a Hoyer lift parked next to the trash cart which further blocked the handrail. On 2/28/14 at 7:30 a.m., the Administrator was informed of the equipment storage issue. However, no further information or documentation was provided.	F 323		
F 329 SS=E	483.25(i) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy), or for excessive duration; or without adequate monitoring; or without adequate indications for its use, or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record, and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Lewiston Rehabilitation & Care Center 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.	

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

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - LEWISTON		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501		
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F 329	<p>Continued From page 36</p> <p>behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to: *Ensure residents were free from unnecessary drugs. *Ensure residents who received antipsychotic medications had an adequate diagnosis and clinical indication for use. *Identify which non pharmacological interventions were attempted. *Ensure residents were monitored for adverse effects, and *Ensure the resident without signs and symptoms of a UTI (urinary tract infection) did not receive unnecessary antibiotics. This practice created the potential for harm should the medication result in or contribute to an unanticipated decline or newly emerging or worsening symptoms. This was true for 5 of 8 sampled residents (#1, 2, 7, 8, and 11). Findings include:</p> <p>1 Resident #8 was admitted to the facility on 9/12/13 with multiple diagnoses including depression, anxiety, and hemiplegia.</p> <p>The resident's Quarterly MDS assessment dated 1/10/14, documented the resident: -Was moderately cognitively impaired with a BIMS score of 8;</p>	F 329	<p>F329</p> <p>Resident Specific The ID team reviewed resident #1, #2, #7, #8 and #11</p> <p>Resident #1- As needed Hypnotic was discontinued (also see F 309)</p> <p>Resident #2- Anitbiotics completed no adverse side effects noted</p> <p style="text-align: right;">4-3-14</p>	

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

PRINTED: 03/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/28/2014
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - LEWISTON		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501		
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F 329	<p>Continued From page 37</p> <p>-Had no potential indicators of Psychosis; -Did not exhibit physical, verbal or other behavioral symptoms towards others; and -Was totally dependent for bed mobility, transfers, dressing, eating, and toilet use.</p> <p>The resident's Physician Progress Notes documented -On 2/3/14, ..."The daughter states the patient tends toward either agitation or somnolence. The family has a strong preference for the latter;" and -On 2/12/14, ..."No problem with her sleep or mood after stopping Trazodone and Lorazepam in 12/2013. Family member note more paranoid. . [start] Risperdal 0.5 mg [milligram]." NOTE: The Physician Progress Notes did not mention a psychiatric diagnoses or what paranoia the resident experienced.</p> <p>The resident's Physician's Order Sheet dated 2/12/14, documented in part . "2. Begin Risperdol [sic] 0.5 mg PO [by mouth] Qhs [at bedtime] to reduce paranoia (noted by her family member)..."</p> <p>The resident's Medication Sheet documented, "risperdol [sic] 0.5 mg qhs [sic] anxiety/paranoia [sic]." The first documented administration of the medication was 2/13/14. NOTE: The Physician's Order Sheet did not list anxiety as an indication for use of the Risperdol.</p> <p>The resident's Care Plan did not address paranoia or accusatory behavior.</p> <p>The resident's Progress notes documented the following -On 2/4/14 at 2:56 PM, "Situation: Staff and family have noted increased paranoia and unrealistic accusations. Dtr [daughter] is asking if meds</p>	F 329	<p>Resident #7- Followed by SJRMC Mental Health gradual dose reduction done 3/7/14 with further reduction to be considered Resident #8- Care plan updated, Behavior monitoring for paranoia and accusation and MAR updated for monitoring of adverse effects. Diagnosis of Paranoia Ideations obtained from MD Resident #11-As needed antipsychotic was discontinued</p> <p>Other Residents The ID team reviewed other residents for psychotropic drug use as well as antibiotic use. For appropriate justification for use, monitoring and GDR. Care plan updated as indicated</p> <p>Facility Systems Licensed Nurses and Social Services are educated to indications /monitoring requirements with use of psychotropic drugs, and indications for use of antibiotics. Re-education was provided to include but not limited to, documentations, indications and monitoring of behaviors/side effects of psychotropic drugs and antibiotics.</p> <p>Monitor The DNS or designee will audit 4 charts for behavior monitoring, appropriateness of care plan and correct diagnosis/indication of psychotropic and or antibiotic medication weekly for 8 weeks. The review will be documented on the PI audit tool, starting 4/3/14. Any concerns will be addressed</p>	

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

PRINTED: 03/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/28/2014
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - LEWISTON		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501		
(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)	
F 329	<p>Continued From page 38</p> <p>need to be change or dose change is needed. Background: No longer being seen by mental health. In December her Trazodone and Ativan were D/C'ed [sic] [discontinued]. Currently taking Lexapro 20 mg Q[every] HS [bedtime] for depression. Assessment [no documentation]. Request: [no documentation].</p> <p>NOTE: Progress notes written in the month prior to this note did not document paranoia or accusations.</p> <p>-On 2/5/14 at 9:09 PM, "Rsdnt [resident] w/o [without] behaviors this shift. Rsdnt pleasant with no complaints. Spouse assisted with dinner. Meds given as scheduled. WCTM [will continue to monitor]."</p> <p>-On 2/6/14 at 2:58 AM, "Resident has slept thru the noc [night]. Has not expressed any paranoia [sic] thoughts. VSS [vital signs stable]."</p> <p>The resident did not have behavior monitoring for paranoia or accusations documented. Additionally, there was no documented monitors for adverse effects of the medication.</p> <p>On 2/26/14 at 4:20 PM, the DNS was interviewed regarding the resident's agitation/accusation and paranoia behavior. When asked why Risperdal was started for the resident the DNS said, "Paranoia is what the original order said, obsessing about her husband... and things that happened in the past. It's not a new problem. This is a difficult family." When asked if the resident had problematic behaviors the DNS replied, "She is not a harm to herself or others. She does not have the capabilities of doing anything now." She acknowledged there was no diagnoses for the resident related to paranoia or accusations and stated the social worker has been working with her on the behaviors as well as</p>	F 329	<p>immediately and identified trends discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p>	

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

PRINTED: 03/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/28/2014
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - LEWISTON		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501		
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F 329	<p>Continued From page 39</p> <p>getting a diagnosis for this. She said, "I want to say dementia with..." The DNS made a phone call to the Admit Clerk. After getting off the phone with the Clerk she said, "She has dementia related psychosis." No documentation was provided regarding this.</p> <p>The facility failed to provide an adequate diagnoses, indications of use, non pharm interventions, behavior monitoring, or monitoring for adverse effects of this medication for the resident.</p> <p>2. Resident #2 was admitted to the facility on 9/12/13 with multiple diagnoses including osteoporosis and pressure ulcers.</p> <p>The resident's Quarterly MDS assessment dated 12/19/13, documented the resident: -was cognitively intact with a BIMS of 15; -required extensive assistance with bed mobility and toilet use; and -had an indwelling urinary catheter.</p> <p>Physician's Orders noted 1/8/14 at 10:00 PM documented, "DC [discontinue] foley cath. UA [with] C&S[culture and sensitivity] if indicated."</p> <p>The Resident's Progress notes included the following. On 1/9/14 at 3:53 AM, "UA back. C&S being done- faxed to [resident's physician]." On 1/9/14 at 1:20 PM, "Rsdrt pos [positive] for UTI, awaiting CNS [culture and sensitivity] On lab. rsdt has several allergies to ABO [antibiotics] Appetite is good fluids are encouraged. Rsdrt denies any increased pain or discomfort," and On 1/10/14 at 1:51 PM, the Progress notes</p>	F 329		

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

PRINTED 03/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/28/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - LEWISTON	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501
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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
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F 329 Continued From page 40
documented, "Rsdrt has no noted c/o [complaint of] pain or discomfort from UTI, awaiting C&S on labs for ABO therapy"

F 329

On 1/12/14 at 7:56 AM, the Laboratory Outpatient Report documented the following UA results. Flagged Protein, blood, Nitrite, Leukocyte Esterase, RBC, WBC, and Bacteria. On 1/15/14 at 11:44 AM, the Laboratory Outpatient Report documented the following Culture and Sensitivity reports: "Use of a synergistic antibiotic, i.e. aminoglycoside, is recommended with systemic infections." On this form, the following order is written: "Macrobid 100 mg PO [by mouth] BID [twice daily] [for] 10 days. DX [diagnosis]: UTI."

On 1/15/14 at 9:33 PM, the resident's Progress Notes documented, "Started macrobid 100 mg [milligram] tonight. Rsdrt has a UTI. No complaints of burning upon urination or frequent urination."

*NOTE: The resident exhibited no signs or symptoms of a UTI. It is unclear why a unalysis and C&S was obtained

The interpretive guidance under F315, related to incontinence and catheter care, states, "Because many residents have chronic bacteriuria (bacteria in the urine), the research-based literature suggests treating only symptomatic UTIs. Symptomatic UTIs are based on the following guidance:
Residents with a catheter should have at least two of the following signs and symptoms:
o Fever or chills;
o New flank pain or suprapubic pain or tenderness;
o Change in character of urine (e.g., new bloody urine, foul smell, or amount of sediment) or as reported by the laboratory (new pyuria or

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

PRINTED: 03/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/28/2014
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501		
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F 329	Continued From page 41 microscopic hematuria); and/or o Worsening of mental or functional status. Local findings such as obstruction, leakage, or mucosal trauma (hematuria - blood in urine) may also be present." On 2/26/14 at 2:15 PM, the DNS and SDC (staff development coordinator) were interviewed. When asked why the UA was ordered on the 1/8/14, the DNS said, "I see, they were asked to remove the foley and get a UA. It was positive so we treated her. I don't know if it is the physician's policy to do that or what.. There was no other indications than that.. There's nothing documented prior to the 8th regarding pain or a fever." When asked if it is common practice at the facility to obtain a UA when a foley is discontinued even without any indication of a UTI, the DNS reported, "It's not a policy; It's the physician." The SCD said, "[The physician], he likes to do that. We have a lot of docs who like to do that. We are trying to teach them." 3 Resident #7 was admitted to the facility on 5/24/06. Resident #7's diagnoses at the time of survey included Dementia Alzheimer's type, severe and progressive; and delusional disorder persecutory type with recent mild symptoms. Resident # 7's most recent Annual MDS, dated 1/20/14, coded *Long term and short term memory deficits, with moderately impaired decision making skills; *No hallucinations, delusions, or other behavioral symptoms. Resident #7's Physician's Orders documented *9/20/10, Haldol 1 mg every day at bedtime for hallucinations/agitation;	F 329			

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

PRINTED: 03/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/28/2014
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - LEWISTON		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501		
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F 329	<p>Continued From page 42</p> <p>*12/18/13, Haldol 0.75 mg every morning for hallucinations/agitation.</p> <p>On 5/17/13, a "Note to Attending Physician/Prescriber" form (Pharmacy recommendation) for Resident #7 documented, "The resident has been on Haldol...since 9/20/2010. Please evaluate the current dose and consider a gradual taper to ensure this resident is using the lowest possible effective/optimal dose..." The "Physician/Prescriber Response" area of the form documented, "Still Delusional at times. Requires this med and dose for stability." The form was signed by the Nurse Practitioner (NP)</p> <p>On 6/26/13, the NP's Mental Health Note documented, ". . . She [the resident] does not appear to have any delusional or paranoid content when I tried to communicate with her, although this was very difficult. She is essentially deaf at this point. She did not appear to be responding to any stimuli...She did not appear to be agitated. . . I do believe that her insight and judgement is almost absent. Her attention and concentration were very poor. . . I am going to continue the patient's current medications . . ."</p> <p>On 11/14/13, a "Consultant Pharmacist's Medication Regimen Review" form documented, "This resident is receiving Haldol. The current monitoring is not capturing any of the targeted behaviors. Please update the current order and behavior monitoring record to include the specific target behavior(s) that can be quantitatively and objectively documented by the nursing staff as required by CMS guidelines. The behavior must be persistent and not due to preventable causes and represent a danger to themselves and/or</p>	F 329		

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

PRINTED 03/10/2014
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/28/2014
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - LEWISTON		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501		
(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 329	<p>Continued From page 43</p> <p>others (including staff). Per CMS 'agitation' is not a specific behavior. Only behaviors that are a threat to the resident or other's safety justify antipsychotic use." The NP's response was, "See orders (DC PRN Haldol.)" NOTE: The resident continued with an order for routine Haldol.</p> <p>On 12/4/13, a "Nursing Home Follow Up" form (identified by the DNS as a form generated by the facility to communicate with the mental health NP) documented, "...no sx of hallucinations, delusions, or fearfulness noted. Current Medications: Haldol 1 mg PO Q HS [by mouth every day at bedtime]; 0.75 mg PO Q AM [by mouth every morning]; Haldol 0.25 mg PO Q 4 hrs. PRN [by mouth every 4 hours as needed] hallucinations/agitation... sleeps well at night - typically 11-12 hours at night. Please review [regarding a gradual dose reduction] Haldol." The NP responded, "[Discontinue] PRN Haldol only."</p> <p>Resident #7's Behavior Monitoring sheets documented target behaviors of Hallucinations, Agitation, and Delusional thinking. For December 2013, January 2014 and February 2014, the monitors documented no behaviors occurred.</p> <p>On 2/24/13 at 9:20 AM, Resident #7 was observed sitting in her room in a wheelchair. The resident made eye contact when the surveyor approached, but had minimal, unintelligible responses to questions or statements. After a few minutes, the resident calmly stated, "I didn't understand you."</p> <p>On 2/24/14 at 12:35 PM, the resident was observed at the lunch meal. She was sitting calmly at the table, receptive to staff assistance to consume her meal.</p>	F 329		

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

PRINTED: 03/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/28/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - LEWISTON	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501
--	--

(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 329 Continued From page 44

F 329

On 2/26/14 at 5:05 PM, the resident was observed at the dinner meal. When offered assistance, she initially stated, "No," but when re-approached a few minutes later was receptive to assistance to consume her meal.

On 2/26/14 at 11:05 AM, the DNS was asked about Haldol use for Resident #7. The DNS was unable to offer clarification on the exact clinical indications for Haldol use for this resident. The DNS stated Haldol had been ordered for the resident for quite some time, and the facility had repeatedly asked the NP for a dose reduction. However, the NP had consistently declined. The DNS stated the facility planned to make this a focus area for this resident during their quarterly "Standards of Care" meeting. The DNS stated the facility had also implemented a new contract with a different NP, who they hoped would be more on board with the new requirements for dementia care. The DNS stated, "I agree with your concern on the Haldol."

On 2/27/14 at 9:50 AM, the DNS approached and stated the MD had been updated that morning regarding the resident's Haldol use. The facility expected a response from the MD that day.

On 2/27/14 at 4:15 PM, the Administrator, DNS, and DDCO were informed of the surveyor's concerns. The facility offered no further information.

4 Resident #1 was admitted to the facility on 10/24/13 with multiple diagnoses which included left hip fracture, chronic ischemic heart disease and hypertension.

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

PRINTED: 03/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/28/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - LEWISTON	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501
--	--

(X4) ID PREFIX TAGS	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 329 Continued From page 45

Resident #1's most recent Quarterly MDS, dated 12/19/13, coded

*Moderately impaired cognitive skills;

*Pain present, requiring routine, as needed, and non-medication interventions; and

*Pain is frequent, with an intensity of an 8 [on a scale of 0 to 10], impacting sleep

Resident #1's Physician's Orders for February 2014 documented an order for Restoril 15 mg at bedtime as needed, beginning 10/24/13.

Resident #1's care plan documented.

[NOTE: Some of the dates on the resident's care plan were documented as 10/23/13, even though the resident was not admitted, and the Restoril not ordered, until 10/24/13.]

*Focus of, "[Resident #1] is on Hypnotic Therapy r/t Diagnosis of Insomnia." Date initiated and date revised both documented as 10/23/13.

*Goal of, "[Resident #1] will be free of any discomfort or adverse side effects of hypnotic use through the review date." Initiated 10/23/13, target date of 3/10/14.

*Interventions of, "Administer medications per physician's order. See medication record. Monitor effectiveness and side effects," and, "May cause day time drowsiness, confusion, loss of appetite in the morning, increased risk of falls and fractures, dizziness. Observe for possible side effects [every] shift." Both interventions were initiated on 10/23/13.

Resident #1's MAR documented the Restoril was used on 1 occasion in January 2014, and 4 occasions in February 2014.

On 2/26/14 at 11:35 AM, the facility was asked to provide sleep monitors for Resident #1, as well as

F 329

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

PRINTED: 03/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/28/2014
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - LEWISTON		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501		
(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)	
F 329	<p>Continued From page 46</p> <p>a care plan for non-medication interventions to be used prior to the Restoril when the resident was having difficulty sleeping.</p> <p>On 2/27/14 at 9:50 AM, the DNS reported the facility did not have sleep monitors in place for this resident. The DNS was unable to identify non-medication interventions to be used prior to the administration of Restoril, as the resident had identified pain as a factor preventing her from sleeping. The DNS stated the facility had faxed the MD with updates on the resident that morning, and was anticipating a response by the end of the day.</p> <p>On 2/27/14 at 4:15 PM, the Administrator, DNS, and DDCO were informed of the surveyor's findings. The facility offered no further information.</p> <p>NOTE: Please see F 309 as it pertains to pain management for this resident.</p> <p>5. Resident #11 was admitted to the facility on 1/28/14 with multiple diagnoses which included dementia, pneumonia, and PTSD (Post Traumatic Stress Disorder).</p> <p>Resident #11's Physician's Orders documented an order for Risperdal 0.5 mg every 8 hours as needed for PTSD, beginning 1/28/14.</p> <p>On 2/10/14, a "Request for Psychiatric Services" form documented, "Review for PRN Risperdal use...family medicine note indicates he felt his medication was poisons [sic]. History of PTSD and nightmares...Previous psychiatric history: None - was admitted to our facility with orders for PRN [Risperdal]. Past Medical [History]:"</p>	F 329		

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

PRINTED: 03/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/28/2014
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - LEWISTON		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501	
(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 329	<p>Continued From page 47</p> <p>Delusional disorder...depression."</p> <p>On 2/11/14, the "Nursing Home Follow-up" from the mental health practitioner documented, "...Did make some statements to me he felt his medicine was poison. States he does not sleep well and has not for some time. No use of PRN [Risperdal] since admit...New Orders: Continue... [Risperdal].]</p> <p>The resident's MAR for February 2014 documented Risperdal was available to the resident, but had not been used. There was no behavior tracking noted for February 2014</p> <p>On 2/26/14 at 11:05 AM, while being interviewed about the use of psychotropic medications, the DNS stated the facility had implemented the use of a new mental health practitioner, who she felt would be more in tune with using those medications only when clearly indicated.</p> <p>On 2/28/14 at 7:30 AM, the Administrator, DNS, and DDCO were informed of the surveyor's findings. The facility offered no further information.</p>	F 329	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Lewiston Rehabilitation & Care Center 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 468 SS=E	<p>483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS</p> <p>The facility must equip corridors with firmly secured handrails on each side.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all corridors were equipped with handrails. This</p>	F 468	<p>F468</p> <p>Resident Specific The ID team reviewed resident number 1 thru 13 no incidents noted related to missing handrails</p>

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

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB - LEWISTON	STREET ADDRESS, CITY, STATE, ZIP CODE 3316 8TH STREET LEWISTON, ID 83501
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F 468 Continued From page 48
affected 13 of 13 (#s 1-13) sampled residents and had the potential to affect other residents who frequented the corridors without handrails. This practice created the potential for residents to not have a handrail for stability when needed. Findings included.

On 2/27/14 at 11:50 AM and 12:00 PM, approximately 15 feet of handrails were observed to be missing on both sides of the hallway leading to the facility's South Entrance and approximately 4 feet of handrails on both sides of the hallway leading to the exit next to the Resident Lounge near room 304.

On 2/27/14 at 1:35 PM, the Maintenance Supervisor was shown the missing handrails and he stated, "I will take care of it"

On 2/27/14 at 4:05 PM the Administrator, DNS, and DDCO were informed of the issue. No further information was provided by the facility.

F 493 483 75(d)(1)-(2) GOVERNING BODY-FACILITY
SS=E POLICIES/APPOINT ADMN

The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required, and responsible for the management of the facility

This REQUIREMENT is not met as evidenced by.

F 468 **Other Residents**
The ID team reviewed other residents for incidents related to missing handrails, none noted

Facility Systems
Handrails to be installed by April 3 2014

Monitor
The Maintenance Manager or designee will inspect t Halls A, B and C handrails for safety concerns on monthly maintenance rounds. The review will be documented on the PI audit tool, starting 4/3/14. Any concerns will be addressed immediately and identified trends discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate

4-3-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 493	<p>Continued From page 49</p> <p>Based on record review, group resident interview and staff interview, the governing body failed to provide appropriate funding and activity staff levels for an effective ongoing program of activities to include sufficient activities in the evenings and on weekends. This was true for 4 of 6 residents who attended the group meeting and had the potential to affect most residents in the facility. This created a potential for psychological harm when residents were provided minimal activities which could potentially create an atmosphere of boredom and foster an increase in negative behaviors. Findings included:</p> <p>The Activity Calendars for November and December 2013 and January and February 2014 were reviewed. The calendars lacked enough scheduled activities throughout the day to maintain resident interests.</p> <p>The November 2013 activity calendar documented for Monday through Friday ranged from 1 to 4 activities scheduled each day and only 6 out of the 21 weekdays had an activity scheduled after 2:15 PM. On Saturday and Sunday there was one activity scheduled for each of these days, along with "Friends and Family" listed on Sundays without a time.</p> <p>The December 2013 activity calendar documented for Monday through Friday ranged from 1 to 4 activities scheduled each day and only 5 out of the 22 weekdays had an activity scheduled after 2:15 PM. On Saturday and Sunday there was one activity scheduled for each of these days, along with "Friends and Family" listed without a time.</p> <p>On 12/25/13 there was only "Friends and Family" listed without a time.</p>	F 493	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Lewiston Rehabilitation & Care Center 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>	

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F 493	<p>Continued From page 50</p> <p>The January 2014 activity calendar documented for Monday through Friday ranged from 1 to 4 activities scheduled each day and only 3 out of the 23 weekdays had an activity scheduled after 2:30 PM. On Saturday and Sunday there was one activity scheduled for each of these days, along with "Friends and Family" listed without a time.</p> <p>The February 2014 activity calendar documented for Sunday through Saturday ranged from 1 to 4 activities scheduled each day and only 8 out of the 28 days had an activity scheduled after 2:30 PM.</p> <p>During the resident Group Interview on 2/25/14 at 10:45 AM, residents were asked about the facility's activity program. Four of the 6 residents in attendance said they wanted more activities, especially in the evenings and on the weekends. They also said the activity program had declined over the past three months with not enough staff to assist residents with activities. One resident in the group stated of the activities, "I wouldn't sleep so much if there more "</p> <p>On 2/27/14 at 8:50 AM, the Activity Director was interviewed regarding the activity issues. When asked about the lack of activities in the late afternoons and evenings, she said they did occasionally conduct random smaller group activities which were not listed on the calendar. When asked what the activity "Friends and Family" was, she stated it was, "Just people coming in," visiting their family or friends who reside in the facility. When asked why there was normally only one activity scheduled on weekend days, she stated, "I guess we need to schedule more." She also stated, "I wish we could have</p>	F 493	<p>F493</p> <p>Resident Specific No specific residents identified</p> <p>Other Residents The ID team reviewed other residents for psychological harm or negative behaviors related to boredom. Adjustments have been made as indicated.</p> <p>Facility Systems Activity hours adjusted to provide staff for evening and weekend activities and adjusted to provide activities for residents later in afternoon</p> <p>Monitor Same as F248 The ED or designee will review activity calendar monthly, attend quarterly resident council meeting to follow up on resident concerns with activities, ADHOC person to attend one resident council meeting per quarter for discussion about activity programs without activity staff, will audit 3 residents for adequate activities weekly for 8 weeks. The review will be documented on the PI audit tool, starting 4/3/14. Any concerns will be addressed immediately and identified trends discussed with the PI</p>	4-3-14

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F 493	<p>Continued From page 51</p> <p>more [activities]. we could offer more " When asked to clarify this statement, she said, she had asked for more hours for activities staff, but was told to use more volunteers instead. When asked how many hours they were budgeted for, she said she and her assistant were each given 32 hours a week. When asked who set the activities budget, she stated, "Corporate sets the activity hours."</p> <p>On 2/27/14 at 9:15 AM, the Administrator was interviewed about the activities budget. She said the facility had two non-full time staff on the weekdays and one staff who worked 2-4 hours each weekend. She said the activity budget was set by the corporation with some input from the administrator, but she stated it, "Comes down to whatever corporate decides."</p> <p>On 2/27/14 at 4:05 PM the Administrator, DNS, and DDCO were informed of the issue. No further information was provided by the facility.</p>	F 493	<p>committee. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p>	

Bureau of Facility Standards

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C 000 16.03.02 INITIAL COMMENTS

The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.
The following deficiencies were cited during the annual licensure and complaint survey at your facility. The team entered the facility on 2/24/14 and exited on 2/28/14. The survey team included:

Nina Sanderson, LSW BSW, Team Coordinator
Brad Perry, LSW BSW
Amy Barkley, RN BSN
Lauren Hoard, RN BSN
Jana Duncan, RN MSN

C 000

This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Transitional Care and Rehabilitation 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.

RECEIVED

MAR 25 2014

FACILITY STANDARDS

C 105 02.100.02 ADMINISTRATOR

02. Administrator. The governing body, owner or partnership shall appoint a licensed nursing home administrator for each facility who shall be responsible and accountable for carrying out the policies determined by the governing body. In combined hospital and nursing home facilities, the administrator may serve both the hospital and nursing home provided he is currently licensed as a nursing home administrator. This Rule is not met as evidenced by Refer to F493 regarding effective support by the governing body for an ongoing activity program.

C 105

Refer to F 493

4/3/14

C 147 02.100.05.g Prohibited Uses of Chemical Restraints

g. Chemical restraints shall not be

C 147

Bureau of Facility Standards

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

TITLE

(X6) DATE 24

STATE FORM

5849

5BCY11

If continuation sheet 1 of 6

Debbie Pege

Executive Director

3/26-14

Per conversation
E Admin 4/3/14
1:10 pm

Bureau of Facility Standards

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C 147	Continued From page 1 used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician. This Rule is not met as evidenced by: Refer to F329 regarding clinical indications for use and unnecessary medication issues.	C 147	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Transitional Care and Rehabilitation 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.	4-3-14
C 173	02.100.12,d Immediate Notification of Physician of Injury d. The physician shall be immediately notified regarding any patient/resident injury or accident when there are significant changes requiring intervention or assessment. This Rule is not met as evidenced by: Please see F 157 as it pertains to physician notification.	C 173	Refer to F 329 Refer to F 157	4-3-14
C 175	02.100.12,f Immediate Investigation of Incident/Injury f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Please see F 225 as it pertains to incident investigations.	C 175	Refer to F 225	4-3-14
C 361	02.108.07 HOUSEKEEPING SERVICES AND EQUIPMENT	C 361		

Bureau of Facility Standards

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C 361	Continued From page 2 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Refer to F252 regarding cracks in resident room floors.	C 361	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Transitional Care and Rehabilitation 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.	
C 389	02 120.03.d Sturdy Handrails on Both Sides of Halls d. Handrails of sturdy construction shall be provided on both sides of all corridors used by patients/residents. This Rule is not met as evidenced by: Refer F468 regarding lack of handrails in corridors.	C 389	Refer to F 252	4-3-14
C 422	02 120.05.p.vii Capacity Requirments for Toilets/Bath Areas vii On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds, one (1) toilet for every eight (8) licensed beds, and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water. This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility did not provide each	C 422	C- 422 With this 2567 we are requesting a continuation of the existing waiver for bathing facilities	4-3-14

Bureau of Facility Standards

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C 422	Continued From page 3 resident floor or nursing unit with least one (1) tub or shower for every twelve (12) licensed beds. This resulted in the facility lacking the number or required tubs or showers. This had the potential to impact all residents at the facility. The findings included: The facility was licensed for 96 residents. However, the facility had only 8 bathing areas available, including the bathing areas in the therapy room. This was confirmed by the Administrator on 2/28/14 during the exit conference starting at 7:30 a.m.	C 422	
C 650	02 150.01.a.vii Resident Care Practices vii Resident care practices, i.e., catheter care, dressings, decubitus care, isolation procedures. This Rule is not met as evidenced by: Refer to F 315 as it relates to catheters.	C 650	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Transitional Care and Rehabilitation 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.
C 674	02 151.01 ACTIVITIES PROGRAM 151. ACTIVITIES PROGRAM. 01. Organized Program. There shall be an organized and supervised activity program appropriate to the needs and interests of each patient/resident. The program shall be designed to include a variety of processes and services which are designed to stimulate patients/residents to greater self-sufficiency, resumption of normal activities and maintenance of an optimal level of psychosocial functioning. It shall include	C 674	Refer to F 315 4-3-14 Refer to F 248 4-3-14

Bureau of Facility Standards

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C 674	Continued From page 4 recreation, therapeutic, leisure and religious activities. This Rule is not met as evidenced by: Refer to F248 regarding insufficient activities in the evenings and on weekends.	C 674	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Transitional Care and Rehabilitation 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. Refer to F 280	4-3-14
C 782	02.200.03.a.iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished. This Rule is not met as evidenced by: Refer to F280 as it relates to care plan revision.	C 782		
C 784	02.200.03.b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please see F 309 as it pertains to assessment and treatment of pain.	C 784		
C 789	02.200.03.b.v Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Please refer to F 314 as it relates to pressure	C 789		

REFER TO F314 4-3-14
Per phone conversation on 4/14/14 at 10:30 am with Administrator. BRAD BEATTY

Bureau of Facility Standards

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C 789	Continued From page 5 ulcers.	C 789		
C 790	02.200.03.b.vi Protection from Injury/Accidents vi. Protection from accident or injury: This Rule is not met as evidenced by: Refer to F323 as it relates to prevention of accidents.	C 790	Refer to F 323	4-3-14



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

March 11, 2014

Debbie Freeze, Administrator
Kindred Transitional Care & Rehabilitation-- Lewiston
3315 8th Street
Lewiston, ID 83501-4966

Provider #: 135021

Dear Ms. Freeze:

On **February 28, 2014**, a Complaint Investigation survey was conducted at Kindred Transitional Care & Rehabilitation-- Lewiston. Jana Duncan, R.N., Lauren Hoard, R.N., Amy Barkley, R.N., Nina Sanderson, L.S.W., and Bradley Perry, L.S.W. conducted the complaint investigation.

This complaint investigation was conducted in conjunction with the facility's recertification and State licensure survey. The survey team reviewed the records of thirteen residents including that of the the identified resident, observed cares provided throughout the facility, and conducted resident and staff interviews.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006110

ALLEGATION #1:

The complainant stated an identified resident was transferred using a stand-pivot transfer rather than a mechanical lift, thereby causing a pressure sore to the foot.

FINDINGS:

The identified resident had a number of medical issues, including but not limited to:

- Hydrocephalus with a history of Ventricular Peritoneal shunt placement;

FILE COPY

Debbie Freeze, Administrator

March 11, 2014

Page 2 of 7

- Progressive Dementia with Behavioral issues;
- Congestive Heart Failure;
- Chronic Obstructive Pulmonary Disease;
- Severe Osteoporosis;
- Severe Peripheral Vascular Disease with Ischemic Ulcer on the Lateral Aspect of the Left Foot;
- Severe Arteriosclerotic Peripheral Vascular Disease with a history of Bypass Grafting;
- Hypertension;
- Seizure Disorder;
- Gastroesophageal Reflux Disease;
- Insulin Dependent Diabetes Mellitus, Type II, with Retinopathy and Neuropathy;
- Dyslipidemia;
- Benign Prostate Hypertrophy with Transurethral Resection of the Prostate;
- History of both right and left hip fractures, with Open Reduction Internal Fixation required to repair both;
- Bilateral Carotid Endarterectomies;
- Malnutrition;
- Acute Renal Failure; and
- Hematemesis.

The identified resident was admitted to the facility with an order for transfer and gait training with physical therapy, and weight bearing as tolerated on his lower extremities. The resident was transferred via a mechanical lift by the nursing staff, but was allowed more aggressive mobility training, per physician's order, while in physical therapy.

The identified resident was seen by the wound clinic. A wound clinic progress note, dated 5/7/13, documented, "...Full thickness diabetic ulcer down to and likely including tendon fascia and possibly bone...It is infected and full of slough...The patient has critical ischemic, left lower extremity...has had vascular intervention in the past...has been seeing [sic] by me in the past when he had severe ulcerations in the lower extremities and primarily the left side...The patient has been doing some transfers on the left foot primarily, and daughter thinks that perhaps this may have flared up some problems, but I think that very likely has had progression of his underlying arteriovascular disease that has been relatively stable, but tenuous for quite some time...has had vascular intervention in the past and today this appears that this is the problem..."

Based on the Wound Clinic Physician's Progress Note, the survey team was unable to substantiate the area on the resident's foot was a pressure ulcer, or that it was caused from bearing weight during transfers.

CONCLUSION:

Debbie Freeze, Administrator
March 11, 2014
Page 3 of 7

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated an identified resident had a history of falls from a regular wheelchair, and was not provided with the type of wheelchair needed to reduce falls.

FINDINGS:

The survey team reviewed the identified resident's care plan, fall history, and clinical records.

There were no documented instances of the resident having a fall from the wheelchair.

There was no physician order for a specialized wheelchair, nor was there therapy or nursing documentation to indicate a specialized wheelchair was necessary.

On February 27, 2014, a staff member was interviewed regarding the identified resident's wheelchair. The staff member stated the facility therapy staff had assessed a standard wheelchair to be appropriate for the resident, as it allowed the resident to propel the wheelchair with his/her arms as they placed their feet on the foot pedals. The staff member stated at one point, there was a therapy referral to work on positioning with the foot pedals, and the resident was placed on therapy caseload. A few days later, the family of the resident brought in a Broda-type wheelchair for the resident to try. The therapists were concerned the Broda wheelchair might be too difficult for the resident to propel and maneuver independently, so rather than automatically placing the resident in the chair, they kept it in the therapy gym so they could assess its use during therapy sessions. The staff member stated before the therapists could complete their assessment of the new wheelchair, the resident was admitted to the acute care hospital on an unrelated matter.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated the identified resident sustained a fall in the facility on a specific date, and the family was not notified for four days. Subsequent to the fall, the resident complained of right leg pain. These complaints of pain were noted at a wound clinic visit, and the resident was sent for a CT scan. The resident was diagnosed with a possible hairline fracture of the right hip and an abdominal mass as a result of the CT completed that day.

Debbie Freeze, Administrator

March 11, 2014

Page 4 of 7

FINDINGS:

The facility documented the resident experienced a fall on the date identified by the complainant. However, facility incident tracking documented the family was notified of the fall 30 minutes after the fall occurred. The day following the fall, the resident was at a physician's appointment and noted to complain of right groin and leg pain. The physician sent the resident to have a CT scan, which was negative for a hip fracture.

The CT of the resident's pelvic mass was completed sixteen days later, as a follow up to an abdominal CT completed almost four months prior. Several abnormalities were noted on the CT, many of which were consistent with the CT completed months earlier. The summary of the abnormalities identified the resident had severe peripheral vascular disease as well as additional extravascular abnormalities. The CT completed at this time also documented an acute comminuted fracture of the right femur. Of note, the resident was hospitalized for the fracture two days later. Per the dates on the report, the information would have not been available to the facility until after the resident was hospitalized.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated an identified resident was identified as having mental problems and referred to a psychiatrist for, "calling out all the time."

FINDINGS:

The identified resident was noted with a behavior of calling out or moaning frequently. Due to his dementia, the facility requested a consultation with a psychologist to rule out mental health issues as a contributing factor. The mental health practitioner assessed the resident, and made recommendations for additional pain control for neuropathic pain. This was in addition to the routine and as needed narcotic pain medication the resident was already receiving.

After reviewing the pain flow sheets for the identified resident, it could not be substantiated the resident's pain complaints were unaddressed by the facility. However, another resident was reviewed for pain control and the facility was found to have a deficient practice, which was cited at F 309.

CONCLUSION:

Debbie Freeze, Administrator
March 11, 2014
Page 5 of 7

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated that the identified resident was admitted to the acute care hospital on a specified date, with a blood glucose level of 35. The complainant stated the facility had ongoing difficulty managing the resident's blood glucose levels.

FINDINGS:

The survey team reviewed the resident's blood glucose levels for the date in question, as follows:

- Morning blood glucose level was 61. Orange juice was given, and 15 minutes later the resident's blood glucose was 80.
- Noon blood glucose was 191.
- At 4:00 PM, the resident's blood glucose was 177.
- At 8:00 PM, the resident's blood glucose level was 93.
- At 8:04 PM, the resident was sent to the acute care hospital for an unrelated matter.
- There was no documentation available in the hospital records reviewed to indicate the resident was experiencing a low blood glucose level. However, the facility had documented an acceptable blood glucose level at the time the resident discharged from the facility.

The survey team also reviewed the resident's blood glucose records for the 4 months leading up to his hospitalization. At times the levels were high or low, but there was no consistent pattern. Each time they were low, the facility documented interventions implemented, and re-checked the resident's blood glucose levels to monitor the effectiveness of the interventions. As the resident's medical condition changed in the months leading to his hospitalization and death, the physician did make occasional adjustments to the resident's routine insulin orders, but the facility always had sliding scale insulin ordered as well.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant stated the identified resident was sent from the facility to the acute care hospital on a specified date, where a right hip fracture was diagnosed.

FINDINGS:

The identified resident was sent to the hospital on the specified date, and was diagnosed with a right hip fracture.

The facility did not document an investigation as to the cause of the hip fracture. A deficient practice was identified and cited at F 225.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #7:

The complainant stated an identified resident was re-admitted to the facility on a specified date following a hospitalization for a hip fracture, and passed away four hours after admission from pneumonia. The complainant stated the facility administered insulin to the resident, but the resident did not eat, which may have contributed to the death.

FINDINGS:

A review of the resident's record confirmed the above information. However, the resident's physician was on-site throughout the time the resident was in the facility that day, and documented the following:

- Shortly after the resident returned from the hospital, the resident was awake, interactive, and eating ice cream with family.
- A short time later, nursing staff noted the resident to require suctioning, with diminished lung sounds.
- The resident progressed to non-responsiveness, and passed away a short time later.
- The physician's documentation stated the resident had been determined to be imminently terminal while in the hospital, and referred to the resident's diagnosis of Chronic Obstructive Pulmonary Disease.
- The Mortician's Receipt, signed by the resident's physician, documented pneumonia as the resident's cause of death.
- The facility did not administer any medications to the resident following his readmission, which was documented due to the resident's non-responsiveness. His blood glucose was taken in the 4 hours he was in the facility on that day, and documented as 114. The resident's Medication Administration Record documented no insulin was given.

Debbie Freeze, Administrator
March 11, 2014
Page 7 of 7

While the report of the complainant did occur as stated, no deficient practice was identified or cited.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

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

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. 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 "LORENE KAYSER". The letters are somewhat stylized and connected.

LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LK/lj