



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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

September 23, 2016

John Schulkins, Administrator  
Kindred Nursing & Rehabilitation - Canyon West  
2814 S Indiana Ave  
Caldwell, ID 83605

Provider #: 135051

Dear Mr. Schulkins:

On **September 9, 2016**, a survey was conducted at Kindred Nursing And Rehabilitation - Canyon West by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 3, 2016**. Failure to submit an acceptable PoC by **October 3, 2016**, may result in the imposition of penalties by **October 28, 2016**.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **October 14, 2016 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **December 8, 2016**. A change in the seriousness of the deficiencies on **October 24, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 8, 2016** includes the following:

Denial of payment for new admissions effective **December 8, 2016**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 8, 2017**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **December 8, 2016** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

John Schulkins, Administrator  
September 23, 2016  
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go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

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

This request must be received by **October 3, 2016**. If your request for informal dispute resolution is received after **October 3, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

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

DAVID SCOTT, RN, Supervisor  
Long Term Care

DS/pmt  
Enclosures

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

PRINTED: 10/12/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135051</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/09/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION - CANYON WEST</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification conducted at the facility from September 6, 2016 to September 9, 2016.</p> <p>The surveyors conducting the survey were:</p> <p>Presie C. Billington, RN, Team Coordinator Jenny Walker, RN Juanita Stamens, RN</p> <p>Definitions include:</p> <p>ADL - Activity of Daily Living AFO - Ankle Foot Orthotic AMA - Against Medical Advice BID - twice a day BLE - Bilateral Lower Extremities BUE - Bilateral Upper Extremities cc - cubic centimeter CT - Computed Tomography DNS - Director of Nursing Services GERD - Gastroesophageal Reflux Disease GI - Gastric Indigestion MAR - Medication Administration Record MDS - Minimum Data Set mgs - milligrams ml - Milliliter NN - Nurses' Notes NPN - Nurse Practitioner Notes NP - Nurse Practitioner PEG - Percutaneous Endoscopic Gastrostomy tube PO - by mouth RES - Resident PRN - As Needed PROM - Passive Range of Motion RNA - Restorative Nursing Aide</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

10/03/2016

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

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F 000	Continued From page 1 ROM - Range of Motion s/s - signs and symptoms UTI - Urinary Tract Infection w/ - with x - times	F 000			
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES  The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.  The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.  This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to ensure 1 of 13 (#9) sampled residents had the right to refuse treatment. This deficient practice had the potential for harm when a Nurse Practitioner (NP) repeatedly declined to honor Resident #9's family request to change her	F 155	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation - Canyon West does not admit that the deficiencies listed on the CMS Form	10/13/16	

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F 155	<p>Continued From page 2</p> <p>pain medication from Percocet to Norco to prevent adverse reactions to Percocet. Findings include:</p> <p>Resident #9 was admitted to the facility on 5/19/15 with multiple diagnoses, including rehabilitation for a fractured left leg sustained from a fall at home. No surgery was performed on the fractured leg.</p> <p>The most recent quarterly MDS assessment, dated 8/13/15, documented Resident #9 had moderately impaired cognition and received scheduled and PRN pain medications.</p> <p>Resident #9's admitting orders, dated 5/19/15, included an order for Norco 10/325 mg every 4 hours PRN for pain and Acetaminophen 650 mg every 4 hours PRN for pain.</p> <p>Resident #9's Nurses' Notes (NN), Nurse Practitioner Notes (NPN), hospital records, and Fall Investigation Report documented:</p> <p>*7/24/15 NN - 6:42 am: Resident #9 was found lying on the floor. She complained of pelvic pain and was sent to a hospital for evaluation.</p> <p>*7/24/15 Hospital x-ray report: Resident #9 had a moderate L2 compression fracture.</p> <p>*7/27/15 NN - 3:05 pm: Resident #9 was discovered moaning in the morning "from pain," pointed to her pelvic area and rated her pain as a "10" on a 10-point severity scale. She received both the scheduled Norco and PRN Norco, both of which were ineffective.</p>	F 155	<p>2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center 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 No changes have been made to resident # 9, as she was discharged prior to survey.</p> <p>Other Residents The ID (interdisciplinary) team reviewed other residents to identify those who may be refusing standard treatments. Adjustments have been made as indicated.</p> <p>Facility Systems Staff and the nurse practitioner is educated to identify and honor resident right to refusal standard treatment. Re-education was provided by the Director of Nursing Services (DNS) and/or the Staff Development Coordinator (SDC) to include but not limited to, resident right to refuse pain medication and/or specific group of pain medications. The system is amended to include review in clinical meeting when residents refuse standard treatments to include pain medication. If not easily resolved and care determined, a resident conference will be established to document the resident chosen course of treatment.</p>		

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F 155	<p>Continued From page 3</p> <p>*7/28/15 NN - 6:30 pm: Resident #9 "continued" to stay in bed and reported her pain as between "6" and "8" on the 10-point scale. She refused to participate in therapy "because of the pain." The NP examined Resident #9 and ordered MS Contin [a morphine medication] every 12 hours for pain and Percocet 5/325 mg every four hours for breakthrough pain.</p> <p>* 7/28/15 NPN - Resident #9 stated she had very poor pain control and any manipulation or movement caused her a significant increase in pain. She rated her pain at "9-10" before receiving medications and at "8" after being medicated.</p> <p>*8/3/15 NN - 1:38 pm: Resident #9 appeared to be oversedated in the morning and was "visually hallucinating" and "verbally aggressive" when she received her morning medications. A family member of Resident #9 told staff Resident #9 "didn't do well" on morphine. Staff called the NP, who "advised" to discontinue Resident #9's MS Contin and continue the Percocet on a PRN basis.</p> <p>*10/14/15 NN - 10:31 am: Resident #9's family member told staff he/she was upset that Resident #9 was receiving Percocet for pain, which had caused her to become "violent and suicidal" in the past. The family member stated Resident #9 had attempted to strike him/her the previous week when he/she attempted to assist her to transfer. Resident #9's family member asked the NP to discontinue Percocet and re-start the Norco. The NN documented the family was not pleased with the NP's response.</p>	F 155	<p>Monitor</p> <p>The DNS and/or designee will audit resident progress notes for refusal of treatment or classes of medications twice weekly for 4 weeks, then once weekly for 8 weeks. Starting the week of October 9th the review will be documented on the PI (Performance Improvement) audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 155	<p>Continued From page 4</p> <p>*10/15/15 NN - 7:12 am: Family was informed Resident #9's pain medication was changed and a family member told the nurse not to ask the resident if she was in pain because she did not need any pain medication. The LN explained to the family member that staff were required to ask Resident #9 about her pain and that it was her right to be free of pain. The family then requested that he/she be present when LNs asked if Resident #9 was in pain.</p> <p>*10/15/15 NN -10:40 am: A family member stated he/she wanted Resident #9 discharged home. When consulted, the NP said he would not write a discharge order and the DON and LSW educated the family member, who then stated he/she wanted to discharge Resident #9 from the facility AMA.</p> <p>* 10/8/16 NPN: Family was "pretty adamant that we avoid any sedating medications as the patient has become quite sedated in the past with narcotic medication ... [Resident #9] states she is otherwise doing well..."</p> <p>* 10/14/15 NPN: A family member asked the NP to discontinue the Percocet and re-start Norco due to Resident #9's history of suicidal ideation when using Percocet in the past. The family member stated Resident #9 was over-medicated and "unresponsive" the previous day from her pain-relieving medications. The NP explained Resident #9 had received Percocet since September, was readmitted to the facility from her most recent hospitalization on this medication, did not express suicidal ideation while she was in the facility, and regularly complained of pain all over her body during each</p>	F 155			

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F 155	Continued From page 5 of his visits with her. The NP explained to family that they could not determine whether Resident #9 was in pain. The NP noted Resident #9 was somewhat sedated the previous day, but did not appear to be in respiratory distress. The NP stated he intended to continue treating Resident #9's pain with Percocet which, he said, was more effective than Norco. The NP documented Resident #9's family member then became "quite upset," and "agitated," before calling another family member to the facility.  The second family member arrived to the facility and told the NP to discontinue the Percocet and re-start the Norco immediately. The family member stated Resident #9 was over-medicated the day before and was having difficulty breathing. The second family member then stated the family would discharge the resident AMA if the Percocet was not discontinued and the Norco reinitiated to address Resident #9's pain.  The NP repeated the information he had provided to the first family member and noted, [In] my own professional opinion ... she would do best with continuation of the Percocet [but] at this point and time we are going to go ahead and change the pain management schedule ..."	F 155			
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  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	F 157		10/13/16	

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F 157	<p>Continued From page 6</p> <p>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 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 staff interview, it was determined the facility failed to ensure the family of 1 of 13 sampled residents (#9) was notified of changes in her pain medications. This failure created the potential for harm when Resident #9's family did not have the opportunity to participate in her health care decisions. Findings include:  Resident #9 was admitted to the facility on</p>	F 157	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation - Canyon West does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves</p>		

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F 157	<p>Continued From page 7</p> <p>5/19/15 with multiple diagnoses including rehabilitation for a fractured left leg, which she sustained from a fall at home. Surgical repair was not performed to the fractured leg.</p> <p>The most recent quarterly MDS assessment, dated 8/13/15, documented Resident #9 had moderately impaired cognition and received scheduled and PRN pain medications.</p> <p>Resident #9's admitting orders, dated 5/19/15, documented an order for Norco 10/325 mg every 4 hours PRN for pain and Acetaminophen 650 mg PRN for pain.</p> <p>Resident #9's Progress Notes and hospital records documented the following:</p> <p>*7/24/15 NN - 6:42 am: Resident #9 was observed lying on the floor. She complained of pelvic pain and was sent to a hospital for evaluation.</p> <p>*7/24/15 - Resident #9's hospital x-ray report documented a moderate L2 compression fracture.</p> <p>*7/28/15 NP Notes: Resident #9 stated her pain control was inadequate and that any manipulation or movement caused her significantly increased pain. The resident stated that her pain is about 9/10 or a 10/10 before medications and about an 8/10 after receiving pain-relief medications.</p> <p>*7/28/15: The NP discontinued Resident #9's Norco and ordered MS Contin 15 mg BID, Percocet 5/325 mg every four hours as needed</p>	F 157	<p>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 No changes have been made to resident # 9, as she was discharged prior to survey.</p> <p>Other Residents The ID team reviewed current residents with pain medication changes since survey to validate that the family and/or responsible party is notified of order changes. Adjustments have been made as indicated.</p> <p>Facility Systems Licensed nurses are educated to notify family and/or responsible party of order changes. Re-education was provided by DNS and/or SDC regarding notification of change to include but not limited to, changes in pain medication. The system is amended to include review of notification in clinical meeting for order changes and/or change of condition updates.</p> <p>Monitor The DNS and/or designee will audit new orders and progress notes for family/responsible party notification of changes twice weekly for 4 weeks, then weekly for 8 weeks. Starting the week of October 9th the review will be documented on the PI audit tool. Any</p>		

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F 157	<p>Continued From page 8 for breakthrough pain.</p> <p>*8/3/15 NN - 1:38 pm: Resident #9 appeared to be oversedated and hallucinating. She became verbally aggressive when the nurse administered morning medications. Resident #9 grabbed the nurse's wrist and would not let it go. A family member was called and said Resident #9 did not respond well to Morphine. The NP discontinued the Morphine and the order for Percocet every 4 hours PRN for pain was left intact.</p> <p>*8/4/15 NN - 5:41 pm: Resident #9 was more alert with no hallucinations.</p> <p>*8/5/15 NN - 9:29 am: Resident #9 was more alert with no complaints of pain.</p> <p>*8/9/15 NN - 3:15 am: Resident #9 was alert and oriented, denied pain, and received medications whole without difficulty.</p> <p>*8/12/15 NN - 1:05 pm: Resident #9 had no complaints of pain or distress.</p> <p>*8/13/15's NN - 6:27 pm: Resident #9 was equipped with a new back brace and stated she was comfortable and experiencing "less pain."</p> <p>*8/16/15 to 8/30/15 NN: Resident #9's pain was relieved with PRN Percocet.</p> <p>*9/10/15 NN: Resident #9 exhibited increased confusion and sediment was observed on her catheter tubing. Her urine was collected and sent to a laboratory.</p> <p>*9/14/15 NN - 2:07 pm: Resident #9's urine</p>	F 157	<p>concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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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F 157	Continued From page 9 culture laboratory result was received by the facility and she was started on Macrobid [antibiotic] 100 mg for 7 days. Resident #9's spouse was notified of the addition of the antibiotic medication.  *10/14/15 NN - 10:31 am: Family Member #1 was upset due to Resident #9's use of Percocet for pain. He/She said Resident #9 had used Percocet in the past and she became violent and suicidal. Family Member #1 also said, that a week ago Resident #9 had hit him/her when he/she assisted her to transfer and his/her glasses went flying. The NN also documented Resident #9's family met with the NP and was not pleased with the response they received.  *10/15/15 - 7:12 am: A family member asked whether Resident #9's pain medication was changed and he/she was informed of the 7/28/15 change.  On 9/9/16, the DON was asked whether Resident #9's family was notified of the Norco being discontinued by the NP on 7/28/15 and the initiation of MS Contin 15 mg BID and Percocet 5/325 mg every 4 hours for breakthrough pain. The DON said there was no documentation Resident #9's family was notified of changes in her pain medications.	F 157			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate	F 278		10/13/16	

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F 278	<p>Continued From page 10 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 staff interview, it was determined the facility failed to ensure MDS assessments accurately documented the status of 2 of 13 (#4 and #10) sampled residents. This created the potential for harm if healthcare decisions were based on MDS assessments that did not accurately reflect the residents' conditions. Findings include:</p> <p>1. Resident #4 was admitted to the facility on 7/25/09 with multiple diagnoses which included cardiovascular accident [stroke] and</p>	F 278	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation - Canyon West does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements,</p>		

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F 278	<p>Continued From page 11 hypertension.</p> <p>Between 9/6/16 and 9/9/16, Resident #4 was observed in bed receiving nutrition via PEG tube connected to a pump infusing at 38 cc/hour.</p> <p>Resident #4's annual MDS assessment, dated 2/14/16, documented she did not have a swallowing disorder and was not using a PEG tube.</p> <p>Resident #4's quarterly MDS assessment, dated 8/16/16, documented she was using a PEG tube but the question as to whether Resident #4 had a swallowing disorder was not answered.</p> <p>On 9/9/16 at 8:45 am, the MDS Coordinator said the MDS section related to a swallowing disorder should have been answered.</p> <p>2. Resident #10 was admitted to the facility on 4/6/15, with diagnoses that included non-insulin dependent diabetes mellitus and renal insufficiency.</p> <p>Resident #10's quarterly MDS assessment, dated 7/14/16, document the resident no longer received dialysis.</p> <p>On 9/7/16 at 10:00 am, Resident #10's was not located in the facility and LN# 1, who was in the hall outside the resident's room, stated Resident #10 was at the dialysis center and would return by lunch time.</p> <p>On 9/9/16 at 1:40 pm, the MDS Coordinator stated the resident currently received dialysis and the current quarterly MDS assessment of 7/14/16</p>	F 278	<p>findings, facts and conclusions that form the basis for the deficiency.</p> <p><b>Resident Specific</b> The ID team reviewed resident # 4 &amp; 10 for errors in MDS coding. Modifications have been made as indicated.</p> <p><b>Other Residents</b> The ID team reviewed other residents for accurate MDS coding for enteral feeding/swallow deficit and dialysis. No addition adjustments were indicated.</p> <p><b>Facility Systems</b> ID team is educated to accurately code the MDS. Re-education was provided by DNS and/or SDC to accurately code the MDS to include but not limited to, enteral feeding, swallowing deficit, and dialysis. The system is amended to include review of significant systems for accuracy on the MDS prior to submission.</p> <p><b>Monitor</b> The Case Manager and/or designee will audit 3 MDSs for significant system accuracy weekly for 4 weeks, then 2 weekly for 8 weeks. Starting the week of October 9th the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 278	Continued From page 12 contained incorrect information that would require modification.	F 278			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, it was determined the facility failed to ensure care plans were reviewed and updated to reflect residents' needs. This was true for 3 of 17 (#3, #4 and #15) sampled residents whose care plans were reviewed and had the potential to affect all other residents in the facility. This deficient practice created the potential for harm if these residents,	F 280	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation - Canyon West does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the	10/13/16	

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F 280	<p>Continued From page 13</p> <p>or others, did not receive appropriate care due to a lack of direction in their care plans. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 5/12/16 with multiple diagnoses, including anxiety, bipolar disorder and recent cerebrovascular accident [stroke].</p> <p>Resident #3's quarterly MDS assessment, dated 7/7/16, documented she was cognitively intact and required extensive assistance of 2 staff members with all her cares, except eating. The MDS documented Resident #3 was incontinent of bowel and bladder.</p> <p>Resident #3's ADL care plan documented she was incontinent of bowel and bladder and required the assistance of 2 staff for toileting.</p> <p>On 9/7/16 at 11:25 am, CNA #1 and CNA #2 were observed providing perineal care to Resident #3. CNA #1 removed Resident #3's soiled adult brief, which was saturated.</p> <p>On 9/7/16 at 11:50 am, both CNA #1 and CNA #2 said they began their shift at 6:00 am and that the 11:25 am observation was the first time they checked and changed Resident #3's adult brief during that shift. CNA #1 said residents should not be left in a soiled adult brief for that length of time and that she and CNA #2 "should have checked the resident's adult brief earlier."</p> <p>On 9/8/16 at 12:45 pm, the DON said Resident #3's care plan did not direct staff to provide incontinence care every 2 hours and as needed.</p>	F 280	<p>alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p><b>Resident Specific</b> The ID team reviewed resident # 3, 4 &amp; 15 for updated care plans which reflect resident current condition. The care plans were adjusted as indicated.</p> <p><b>Other Residents</b> The ID team reviewed other residents for updated care plans which reflect resident current condition. Adjustments have been made as indicated.</p> <p><b>Facility Systems</b> Licensed nurses and ID team are educated to keep resident care plans current with each change. Re-education was provided by the DNS and/or SDC to keep care plans current to include but not limited to, incontinent management/toileting plans, current medications, and splint use. The system is amended to include review in clinical meeting with changes of condition. ID team is to review critically at the time of care conference.</p> <p><b>Monitor</b> The nursing supervisor and/or designee will audit order changes and/or change of condition residents twice weekly for 4 weeks, then weekly for 8 weeks. Starting the week of October 9th the review will be</p>		

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F 280	<p>Continued From page 14</p> <p>2. Resident #4 was admitted to the facility on 7/25/09 with multiple diagnoses, including hypertension and cerebrovascular accident.</p> <p>Resident #4's care plan, revised on 5/24/16, documented staff were to provide "diabetes medication" as ordered and monitor/document for side effects and efficacy. Anti-hypertensive medications were also to be given as ordered by the physician and staff were to monitor for side effects, such as orthostatic hypotension and tachycardia, and efficacy.</p> <p>Resident #4's July, August and September 2016 recapitulated physician's orders did not include an order for diabetes or anti-hypertensive medications.</p> <p>On 9/7/16 at 3:25 pm, the DON said Resident #4 no longer received diabetic or anti-hypertensive medications and the care plan should have been reviewed and updated.</p> <p>3. Resident #15 was admitted to the facility on 2/29/16 with multiple diagnoses, including diabetes.</p> <p>On 9/7/16 between 10:30 am and 11:30 am, Resident #15 was observed wearing an AFO to his right leg. Resident #15's care plan did not include the AFO.</p> <p>On 9/8/16 at 3:10 pm, Resident #15 was observed in bed wearing the AFO on his right leg. When asked how long the AFO was kept on, Resident #15 said he "always" wore the AFO, even while in bed.</p>	F 280	<p>documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 280	Continued From page 15 On 9/8/16 at 3:23 pm, CNA #3 was asked if Resident #15 should wear the AFO while in bed; CNA #3 did not answer.	F 280			
F 281 SS=D	On 9/9/16 at 9:52 am, the DON said Resident #15 did not have an order for the AFO and it was not part of his care plan. 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure care provided to 3 of 17 (#1, #4, and #5) sampled residents was provided consistent with accepted standards of practice. As a result, a) Resident #1 received treatment for a pressure ulcer without physician orders in place to direct the care and was administered medication without a physician order for the medication; b) Resident #4's feeding tube was not flushed consistent with physician orders; and c) Resident #5 did not receive a 72-hour neurological check when she hit her head as the result of a fall. These deficient practices had the potential to adversely affect or harm residents whose cares were not delivered according to accepted standards of clinical practice. Findings include:  1. Resident #4 was admitted to the facility on 7/25/09, with multiple diagnoses which included cerebrovascular and hypertension.	F 281	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation - Canyon West does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.  Resident Specific The ID team reviewed •Resident #4 enteral flush system setting. Rounds validate the order is being accurately followed. •Resident #1 currently has an order for dressing changes and the Pantoprazole	10/13/16	

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F 281	<p>Continued From page 16</p> <p>The most recent quarterly MDS assessment, dated 8/16/16, documented Resident #4 had a PEG tube.</p> <p>On 9/6/16 at 9:55 am, Resident #4 was observed lying in bed with her PEG tube connected to a pump next to the bed. The pump was attached to an IV pole and on the IV pole hung a bag of water and Isosource HN 1.2, which were connected to the machine. The pump read "38 cc/hour, flush 50 ml q 3 hours." LN #3 said the machine was set to flush water at 50 ml every 3 hours.</p> <p>On 9/6/16 at 1:00 pm, Resident #4 was observed sitting in a Broda chair outside her room and the PEG tube was not connected to the pump. LN #2 said Resident #4's PEG tube ran 22 hours a day and was off for two hours a day.</p> <p>On 9/6/16 at 3:23 pm, Resident #4 was observed lying in bed with her feeding tube connected to the pump. The pump read "38 cc/hour, flush 50 cc q 3 hours."</p> <p>Resident #4's MAR for September 2016 documented, "...flush feeding tube with 65 mls of water every three hours."</p> <p>On 9/7/16 at 12:15 pm, the DON said physician orders specified a 65 ml flush every 3 hours. At this time, the DON went to Resident #4's room and checked the pump, which he confirmed was set for a 50 ml flush every 3 hours.</p> <p>2. a Resident #1 was admitted to the facility on 8/2/16 with multiple diagnoses including an above-the-knee amputation of the left lower</p>	F 281	<p>has been discontinued as noted in the CMS-2567.</p> <ul style="list-style-type: none"> <li>•No changes were made retroactively to resident #5 post fall record.</li> </ul> <p><b>Other Residents</b> The ID team reviewed other residents for enteral flush orders, current dressing change orders, formulary changes completed, and complete neurological checks post fall. Adjustments have been made as indicated.</p> <p><b>Facility Systems</b> License nurses are educated to validate that care provided is consistent with acceptable standards of practice. Re-education was provided by DNS and/or SDC to include but not limited to, validate the enteral pump flush is set at prescribed amount, physician orders are followed for wound care, when medications are changed to formulary that the discontinued order is deleted, and neurological checks are completed or physician orders are received to discontinue post ER visit are documented. The system is amended to include review in morning meeting and/or on clinical rounds.</p> <p><b>Monitor</b> The nursing supervisor and/or designee will audit enteral feedings, wound care, and formulary changes for accurate implementation twice weekly for 4 weeks, then weekly for 8 weeks. Starting the week of October 9th the review will be</p>		

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F 281	<p>Continued From page 17</p> <p>extremity and a pressure ulcer to the coccyx.</p> <p>The initial pressure ulcer report, dated 8/2/16, documented Resident #1 had a Stage II pressure ulcer to the coccyx that measured 7.5 cm x 7.0 cm upon admission to the facility. The nurse documented staff cleansed the wound and covered it with Mepilex upon admission.</p> <p>On 9/7/16 at 11:30 am, RN #1 was observed changing Resident #1's coccyx dressing. The pressure ulcer measured 0.4 cm x 0.3 cm x 0.1 cm. RN #1 cleaned the coccyx wound, patted it dry with a clean gauze, and applied a Mepilex dressing. Resident #1's record did not include a physician's order for wound care to the coccyx pressure ulcer.</p> <p>On 9/8/16 at 5:15 pm, the DNS stated there were no standing orders for wound care, and acknowledged there was no physician order to provide wound care to Resident #1's coccyx pressure ulcer until 9/7/16.</p> <p>b. Resident #1 was admitted to the facility on 8/2/16 with multiple diagnoses including GERD.</p> <p>The written physician's orders had an interchange order from the pharmacy, dated 8/2/16, to discontinue Pantoprazole Sodium and to continue with Omeprazole 20 mg daily.</p> <p>The August 2016 MAR documented the Pantoprazole Sodium was administered to Resident #1 every day from 8/3/16 to 8/31/16. On 8/19/16 the MAR documented the facility was "out" of Pantoprazole Sodium.</p>	F 281	<p>documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 281	<p>Continued From page 18</p> <p>The electronic Physician's Order Summary Report for September 2016 documented Resident #1 was ordered two medications for GERD: Omeprazole 20 mg daily and Pantoprazole Sodium 40 mg daily.</p> <p>The September 2016 MAR documented the Pantoprazole Sodium was administered every day from 9/1/16 to 9/6/16.</p> <p>On 9/6/16 at 3:20 pm, LN #4 stated she administered only the Omeprazole because the facility did not receive Pantoprazole from the pharmacy.</p> <p>On 9/6/16 at 3:25 pm, the DNS discontinued the Pantoprazole and stated the medication should have been discontinued on 8/2/16. The DNS verified with the pharmacy that Pantoprazole was not delivered to the facility for Resident #1.</p> <p>3. Resident #5 was re-admitted to the facility on 8/20/16 with multiple diagnoses including a GI bleed.</p> <p>An Incident and Accident Report documented Resident #5 was found on her bedroom floor in a supine position with an occipital hematoma on 8/21/16 at 10:20 am. Neurological checks were initiated and Resident #5 was sent to the ER for further evaluation. Resident #5 returned to the facility at 2:00 pm the same day. A CT scan performed at the hospital documented, "No acute intracranial abnormality identified."</p> <p>When Resident #5 returned from the ER at 2:00 pm, the facility resumed the neurological checks until 7:00 pm.</p>	F 281			

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F 281	Continued From page 19  The facility's Neurological Evaluation policy and procedure documented staff were to conduct neurological assessments every 15-minutes for an hour; every 30-minutes for an hour; every hour for two hours; and then every four hours until a physician determined the evaluations were no longer necessary. The neurological evaluations were to conclude 72 hours after they were initiated if the resident's condition was stable with no signs or symptoms of neurological injury.  The facility failed to follow its Neurological Evaluation policy and procedure; the evaluations should have continued every four hours until 11:00 am on 8/23/16.  On 9/8/16 at 2:30 pm, the DNS said the facility did not have further documentation of neurological assessments for Resident #5.	F 281			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure 1 of 12 (#9) sampled residents whose ADL care was reviewed, received assistance with ADLs, including bathing, as directed by her plan of care.	F 312	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation - Canyon West does not admit that the	10/13/16	

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F 312	<p>Continued From page 20</p> <p>This deficient practice placed Resident #9 at risk of psychosocial harm due to lack of hygienic practices. Findings include:</p> <p>Resident #9 was admitted to the facility on 5/19/15, with multiple diagnoses including rehabilitation for a fractured leg.</p> <p>Resident #9's ADL Care Plan, dated 5/27/15, documented she required the assistance of one staff to complete her showers.</p> <p>The ADL flow sheet documented Resident #9 was to receive a shampoo, shower/bath 2 times a week. Resident #9 received her first bath 6 days after she had been in the facility. Between 5/20/15 and 5/31/15, Resident #9 had two baths. There was no documentation in her ADL record that she refused a bath.</p> <p>On 9/9/16, the DON said there was no documentation of the reason Resident #9 received only two baths between 5/20/15 and 5/31/15.</p>	F 312	<p>deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center 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 No changes have been made to resident # 9, as she was discharged prior to survey.</p> <p>Other Residents The ID team reviewed current resident shower schedules and the documentation of showers. Those residents without at least 2 showers within 7 days were identified and corrective measures were implemented. Care plans were updated as indicated.</p> <p>Facility Systems Clinical staff is educated to provide showers as planned. Re-education was provided by DNS and/or SDC to include but not limited to: providing showers as planned, establishing individualized showering schedules per resident choice, and manage residents who refuse showers providing alternatives. The system is amended to include electronic documentation validation in morning meeting.</p> <p>Monitor</p>		

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F 312	Continued From page 21	F 312	The nursing supervisor and/or designee will audit bathing documentation for task completion three times a week for 4 weeks, then once weekly for 8 weeks. Starting the week of October 9th the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		
F 318 SS=D	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents with limited range of motion [ROM] and contractures received necessary services to prevent further decline in their condition. This was true for 1 of 6 (#4) sampled residents reviewed for ROM and had the potential to cause harm when Resident #4 was not provided exercises to promote the strengthening of both lower extremities. Findings include:</p> <p>Resident #4 was admitted to the facility on</p>	F 318	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation - Canyon West does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form</p>	10/13/16	

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F 318	<p>Continued From page 22 7/25/09 with multiple diagnoses, including hypertension and stroke.</p> <p>The most recent quarterly MDS assessment, dated 8/16/16, documented Resident #4 had a PEG tube and was totally dependent on staff for all of her ADLs. The quarterly MDS assessment also documented Resident #4 had impairment on both sides of her upper and lower extremities.</p> <p>Resident #4's care plan documented, "RNA to assist w/ BLE stretches 6-7 x week...RNA to assist w/extensive PROM bilateral upper extremities ..."</p> <p>On 9/6/16 at 10:45 am, RNA #1 was observed performing a restorative program for Resident #4's upper extremities. When asked if Resident #1 had a restorative program for her lower extremities, RNA #1 said the PT told her Resident #1 only required a restorative nursing program for her upper extremities and not for her lower extremities.</p> <p>On 9/7/16 at 3:25 pm, RNA #1 provided a copy of Resident #4's Rehabilitation Referral for Nursing Programs, dated 11/27/15. The RNA referral documented "ROM of BUE and BLE."</p>	F 318	<p>the basis for the deficiency.</p> <p><b>Resident Specific</b> The ID team reviewed resident #4 restorative programs and clarified the language to provide range of motion (ROM) to bilateral upper and lower extremities. The care plan is updated as indicated.</p> <p><b>Other Residents</b> The ID team reviewed other residents on ROM to validate the intended extremities were included in the program and that the restorative nursing assistant (RNA) was providing the care as indicated. Adjustments were made as indicated.</p> <p><b>Facility Systems:</b> Clinical staff is educated to follow the restorative plans as documented. Re-education was provided by the DNS and/or SDC to include but not limited to, validating the ROM program is clear. The system is amended to include review for clarity with the monthly or quarterly licensed nurse review.</p> <p><b>Monitor</b> The restorative nurse coordinator and/or designee will audit three resident programs for clear directives and implementation weekly for 4 weeks, then two resident programs weekly for 8 weeks. Starting the week of October 9th the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed</p>		

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F 318	Continued From page 23	F 318			
F 369 SS=D	<p>483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS</p> <p>The facility must provide special eating equipment and utensils for residents who need them.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview it was determined the facility failed to ensure special eating equipment was provided to residents who needed it. This was true for 2 of 2 sampled residents (#3 and #17) in need of adaptive dining equipment and had the potential to negatively impact the residents' nutritional status. Findings include:</p> <p>1. Resident #3's nutritional care plan, initiated on 6/16/16, documented staff were to provide a lipped plate and small built-up spoon for dining at meals and snacks, and to provide her with feeding assistance as needed.</p> <p>On 9/7/16 at 8:30 am, Resident #3 was observed eating breakfast in her room. She attempted to bring a spoon of oatmeal to her mouth, but spilled a portion of it on her chest. Resident #3 said she was upset with spilling food on herself. The dietary card on Resident #3's breakfast tray documented she was to be provided with a lipped plate and a built-up spoon, neither of which were placed on her breakfast tray. Resident #3's</p>	F 369	<p>with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation - Canyon West does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center 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 residents #3 &amp; 7. Rounds validate that they have adaptive eating devices as ordered.</p> <p>Other Residents The ID team reviewed other residents with adaptive eating devices orders. Devices were in place and/or adjustments</p>	10/13/16	

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F 369	Continued From page 24 oatmeal was in a regular bowl and she was provided with a regular spoon. When CNA #1 entered the room and asked Resident #3 if she would like help with eating her food, Resident #3 responded that she wanted some assistance. When asked the reason Resident #3 was not provided with adaptive eating equipment, CNA #1 did not answer.  2. Resident #17 was admitted to the facility on 11/5/15, with multiple diagnoses including dementia with behavioral disturbances.  On 9/6/16 at 12:35 pm, a CNA was observed assisting Resident #17 to eat lunch. The CNA attempted to give Resident #17 a drink of nectar thick water from a regular glass, but Resident #17 did not open his mouth. The CNA gave him a spoonful of pureed food and attempted to give him another drink of nectar thick water, but he again did not open his mouth. Resident #17's meal card on the table documented he was to be provided with a lipped plate and "sippy cup."  On 9/6/16 at 1:00 pm, LN #4 said Resident #17 was always assisted with eating and should have a sippy cup for all his drinks.	F 369	made as indicated.  Facility Systems Clinical and dietary staff is educated to provide adaptive eating devices as ordered. Re-education was provided by DNS and/or SDC to include but not limited to, validation at each meal the correct adaptive eating devices is available as ordered for the resident, if it is not provided it is to be requested from the kitchen. The system is amended to include staff delivering the trays are to validate the devices listed on the tray care are provided to the resident and resolve any concerns as indicated.  Monitor The general manager (GM) of culinary services and/or designee will audit for adaptive eating device implementation on four meals weekly for 4 weeks, then two meals weekly for 8 weeks. Starting the week of October 9th the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371		10/13/16	

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F 371	<p>Continued From page 25 under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility policy and procedures review, it was determined the facility failed to ensure food handling and kitchen sanitizing processes were conducted under sanitary conditions to prevent cross contamination and/or foodborne illnesses for 10 of 13 sampled residents (#1, #2, #3, #5, #6, #7, #8, #10, #11, and #13) who received their meals from the kitchen. In addition to the sampled residents, this failure had the potential to affect the remaining 39 of 51 residents in the facility who received their meals from the kitchen. Findings include:</p> <p>On 9/6/16 between 11:00 am and 12:50 pm, the following observations were made in the kitchen:</p> <p>1. Cook #1, while checking holding temperatures of food on the steam table continued to use an oven mitt that she had dropped on the floor to remove a pan of refried beans from the steam table for additional heating. When removing the pan with the dirty oven mitt, the mitt dipped into the beans. After heating the beans to the appropriate temperature, Cook #1 replaced the pan of beans onto steam table.</p> <p>On 9/8/16 at 3:00 pm, the kitchen General Manager stated Cook #1 should have replaced the dropped mitt with a clean one and placed the</p>	F 371	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation - Canyon West does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center 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 GM of culinary services and the executive director (ED) reviewed residents #1, 2, 3, 5, 6, 7, 8, 10, 11, 13, &amp; other residents potentially affected by the contaminated mitt, unsanitary touching of tray cards, and too low of parts per million of sanitizer in the rinsing sink. No changes were made retroactively for these residents.</p> <p>Other Residents The GM of culinary services and the ED have reviewed kitchen sanitation to validate unsanitary deficient practices are</p>		

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F 371	<p>Continued From page 26 dirty mitt into the laundry.</p> <p>2. Cook #2 was observed licking her fingers to sort through resident food tickets during meal service at 12:30 pm. After sorting through the tickets, the cook prepared the trays and placed the tickets onto trays with food without first washing her hands after licking her fingers.</p> <p>3. Kitchen Aide #1 was observed washing dirty pots used for the preparation of the noon meal. A test of the third sink, used for sanitizing showed the sanitizing level was 150 ppm (parts per million). The instructions on the Oasis 146 Multi-Quat Sanitizer recommended a 250 ppm sanitizing level to be effective.</p> <p>On 9/8/16 at 3:00 pm, the kitchen General Manager stated staff have been directed to maintain a 200 ppm sanitizing level for the third sink.</p> <p>The above negative practices placed Residents #1, #2, #3, #5, #6, #7, #8, #10, #11, and #13, who received their meals from the kitchen, at risk of adverse outcomes.</p>	F 371	<p>no longer taking place. Adjustments have been made to correct the situation immediately. No adverse effects have occurred with the residents.</p> <p><b>Facility Systems</b> The culinary services staff is educated to sanitary practices for food service. Re-education was provided by the GM of culinary services and/or the ED to include but not limited to, management of items dropped on the floor, unsanitary practice of using a licked finger to separate meal tray cards, and validating that the parts per million of chemicals meet the sanitation standard at the time of use.</p> <p><b>Monitor</b> The ED and/or designee will audit four meals for sanitary practices per week for 4 weeks, then two meals per week for 8 weeks. Starting the week of October 9th the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		