



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 1826**

March 3, 2014

John A. Schulkins, Administrator  
Kindred Nursing & Rehabilitation - Canyon West  
2814 South Indiana Avenue  
Caldwell, ID 83605-5925

Provider #: 135051

Dear Mr. Schulkins:

On **February 14, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Kindred Nursing & Rehabilitation - Canyon West 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.

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 17, 2014**. Failure to submit an acceptable PoC by **March 17, 2014**, may result in the imposition of civil monetary penalties by **April 7, 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.

- The administrator must sign and date the first page of both the federal survey report, Form

John A. Schulkins, Administrator  
March 3, 2014  
Page 3 of 4

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 14, 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)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)  
[2001-10 IDR Request Form](#)

John A. Schulkins, Administrator  
March 3, 2014  
Page 4 of 4

This request must be received by **March 17, 2014**. If your request for informal dispute resolution is received after **March 17, 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 letters are somewhat stylized and slanted.

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

LKK/dmj  
Enclosures

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 annual recertification survey and complaint investigation. The team entered the facility on 2/10/14 and exited on 2/14/14</p> <p>Team Members conducting the survey were: Nina Sanderson, LSW BSW - Team Coordinator Brad Perry, LSW BSW Susan Gollobit RN Jana Duncan RN MSN</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview of Mental Status CAA = Care Area Assessment CNA = Certified Nursing Assistant CC/cc = Cubic Centimeter CVA = Cerebrovascular Accident DDCO = Divisional Director of Clinical Operations DON/DNS = Director of Nursing Services Hx = History IDT = Interdisciplinary Team LN = Licensed Nurse LPN = Licensed Practical Nurse MAR = Medication Administration Record TAR = Treatment Administration Record MDS = Minimum Data Set MG = Milligrams PO = By Mouth PRN/pm = As Needed RN = Registered Nurse Pt = Patient UTI = Urinary Tract Infection DM = Diabetes Mellitus DJD = Degenerative Joint Disease ROM = Range of Motion Res = Resident</p>	F 000		<p><b>RECEIVED</b></p> <p><b>MAR 17 2014</b></p> <p><b>FACILITY STANDARDS</b></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

*John M. [Signature]* *Executive Director* *3/17/2014*

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.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(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	Continued From page 1 PRN = As Needed VP = Ventriculoperitoneal	F 000			
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.  This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and record review, it was determined the facility failed to ensure call lights were within reach for 4 of 15 sampled residents (#1, 5, 6, 8). The deficient practice had the potential to cause more than minimal harm should resident's needs not be met. Findings included:  1. Resident #8 was admitted to the facility on 2/19/06 with diagnoses that included, senile dementia, osteoarthritis and depressive disorder.  The resident's Care plan documented: *Focus: (Resident's name) has an impaired communication problem r/t (related to) dementia. Date Initiated: 7/16/13. *Interventions: -"Ensure/provide a safe environment: Call light in reach, adequate low glare light, bed in lowest position and wheels locked, avoid isolation." Date initiated: 7/16/13	F 246	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.  F246 <b>Resident Specific</b> Interdisciplinary (ID) Team rounds verify that call lights are within reach for resident # 1, 5, 6, & 8.  <b>Other Residents</b> ID Team reviewed resident ease of access to their call lights. Call lights were adjusted as indicated so that they were easily accessible. In addition, call cord colors were changed from white to other colors to make them easier to find for those residents who self ambulate, self reposition in bed, or have increased visual contrast needs.		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605	
(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 246	<p>Continued From page 2</p> <p>On 2/11/14 at 8:35 am, the resident was in her room, in her w/c (wheelchair), sitting in front of her television. The resident's call light was placed behind the resident, on the top half of her bed which was to the right of her, not within reach of the resident. The resident stated, "I need to go to the bathroom." When the resident was asked how she would get staff to help her, she looked around and stated, "I holler a lot."</p> <p>On 2/11/14 at 8:55 am, the resident and call light remained in the same position as 8:35 am, with the resident dozing at this time. The resident had her oxygen cannula in her hand. LN#21 was notified and went into the room. The LN placed the oxygen cannula in the resident's nose, checked the oxygen companion, and the residents alarm on the her w/c. As the LN started to leave the room, the surveyor was asked if the resident was able to use her call light. LN#21 stated, "She can't if it is way over here." The LN#21 pulled the resident's w/c back and moved the call light to the foot of the bed within reach of the resident.</p> <p>On 2/12/14 at 6:45 pm, the resident was in bed. The resident's call light was on the floor at the foot of the resident's roommate's bed, not within reach of the resident.</p> <p>On 2/13/14 at 10:07 am, the DON and DDCO were informed of the findings. No additional information was provided.</p> <p>2. On 2/10/14 at 3:00 PM Resident #5 was observed in his wheelchair, in his room to the right side of his bed with a plastic water cup in his right hand. His call light was draped over the left side rail of his large bariatric bed. The call light</p>	F 246	<p><b>Center Systems</b> Staff is educated upon hire regarding resident call light use to include but not limited to, resident ease of access to their call light. Staff Development Coordinator (SDC) and Director of Nursing Services (DNS) has re-educated staff and ID Team regarding proper placement, ease of visual identification, and proper response. ID Team and clinical nursing rounds assist with ongoing validation of call light accessibility.</p> <p><b>Monitor</b> The DNS, ID Team, and/or designee will review the placement of call lights within resident reach, as well as response to activation of a call light on 4 shifts weekly for 4 weeks, then 2 shifts weekly for 4 weeks. Starting the week of March 17, 2014, documentation will take place on the Performance Improvement (PI) Audit Tool. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p> <p><b>Date of Compliance</b> March 21, 2014</p>	

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 246	<p>Continued From page 3</p> <p>was out of reach of the resident.</p> <p>From 3:00-3:07 PM, LN #2 was observed passing medications to Resident #5. CNA #1 was also seen within the same period. The CNA placed fresh folded linens on the foot of the resident's bed, repositioned the resident in his wheelchair, and left the room.</p> <p>At 3:07 PM CNA #1 was interviewed and was asked about the resident's call light and she stated, "I didn't check on his call light, I will go back and do that." CNA #1 then went into the resident's room, placed the resident's call light in his lap, and told the resident to use the call light if he needed anything.</p> <p>3. Resident #6 was admitted to the facility on 10/27/08 with multiple diagnoses including Parkinson's disease.</p> <p>Resident #6's most recent quarterly MDS, dated 11/12/13, coded extensive assistance of one person for wheelchair mobility.</p> <p>On 2/10/14 at 9:10 AM, during the initial tour of the facility, Resident #6 was observed sitting in his wheelchair in his room. He had an over bed table in front of him with his breakfast tray on it. There was a puddle of juice splattered on the floor to the left of his wheelchair, with an empty glass on the floor nearby. His fork was on the floor directly under his wheelchair. There were a number of smashed Cheerios on the floor to the right of his wheelchair. The resident was attempting to eat his remaining Cheerios from his bowl with his fingers. The resident's call light was clipped to his bed approximately 2 feet from the resident's reach. When the surveyor entered the</p>	F 246			

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>136051</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 246	<p>Continued From page 4</p> <p>room, the resident stated, "I spilled my juice." The resident was asked how he could alert the nurse he had spilled his juice and needed assistance. The resident looked around the room. His gaze stopped when he saw the call light clipped to his bed. He looked back at the surveyor and stated, "Right now I'd just have to yell."</p> <p>On 2/10/14 at 9:40 AM, LN # 12 was informed of the surveyor's observation. The LN stated, "Oh, that's not OK," and went to check on the resident.</p> <p>4. On 2/10/14 at 11:35 AM, Resident #1 was observed in bed. Her call light was observed to be on the floor to the left of her bed, where she could not access it. The resident had received cares at approximately 11:20 AM, and four staff members were observed exiting her room following cares. The resident, when asked how she would get help if she needed it, said, "I would use the call light." Resident #1, when asked to locate her call light, was unable to find the call light. When asked if she usually had trouble finding her call light, the resident, "I sometimes have trouble finding it because I wiggle around so much."</p> <p>At 11:45 AM, the surveyor showed the call light on the floor to a staff member. The staff picked up the call light, unwrapped it from the head board of the bed and attached it to Resident #1's blanket where she could reach it.</p> <p>On 2/13/14 at 6:05 PM, the DON, DDCO, Executive Director and the DDCO corporate supervisor were notified of concerns.</p> <p>No further information was received regarding this issue.</p>	F 246			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605	
(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 248 F 248 SS=E	Continued From page 5 483.15(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 observation, record review, group and individual resident interview and staff interview, the facility failed to provide an ongoing program of activities to include: - A calendar of activities with variety built into the daily programs; - Sufficient activities in the evening and on Saturdays; - Activities based on assessments for 1 resident who triggered for activities; and - Activities based on the resident's care plan for 1 resident. This was true for 2 of 9 (#5 & 8) sampled residents reviewed for activities, 6 of 15 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 potentially could create an atmosphere of boredom and foster an increase in negative behaviors. Findings included:  1. The Activity Calendars for November and December 2013 and January and February 2014 were reviewed. The calendars lacked variety and enough scheduled activities throughout the day to maintain resident interests. There were no	F 248 F 248	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.  F 248 <b>Resident Specific</b> ID Team reviewed the process related to the ongoing program of activities for resident # 5, 7, & 8. A variety and increased number of opportunities for resident activities are now in place for residents to choose in order to meet their psychosocial needs. Care plans were adjusted as indicated to address resident individual life patterns and choices. Participation records reflect resident attendance.  <b>Other Residents</b> ID Team reviewed resident MDS for resident individual life patterns and choices. ABAQIS activity participation resident interview completed for residents that can be interviewed. Care plans were updated as indicated to provide an ongoing program of activities that meet resident desires.	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605	
(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 248	<p>Continued From page 6</p> <p>activities scheduled after 12:00 PM on Saturdays, other than Afternoon Leisure Time, and no activities scheduled after 3:00 PM Monday through Friday, with only one exception for a 6:30 PM activity on 12/18/13.</p> <p>The November 2013 activities were: *10:00 AM- Coffee and either Donuts or a game or reading activity (Sunday-Friday); *10:00 AM- Walmart (3rd Wednesday) *11:00 AM- Exercise Group (Sunday-Saturday); *12:00 PM- Lunch Social (Sunday-Saturday); *2:00 PM- Parma Revival (2nd &amp; 4th Sunday); *2:30 PM- a Game or Leisure activities (1st &amp; 3rd Sunday); and *3:00 PM- Bingo, Crafts, a Music program (3 occasions), a Game, Resident Council, or a Movie (Monday-Friday). The calendar also contained activities without times for LDS Church visit for 3 Sundays, Catholic &amp; Jehovah Witness Visit every Thursday, and Beauty Shop every Tuesday.</p> <p>The December 2013 activities were: *10:00 AM- Coffee and either Donuts or a game or reading activity (Sunday-Friday); *10:30 AM- Walmart (2nd Thursday); *11:00 AM- Exercise Group (Sunday-Saturday); *12:00 PM- Lunch Social (Sunday-Saturday); *2:00 PM- Parma Revival (2nd &amp; 4th Sunday); *2:00 PM- Nails (3rd Sunday); *2:30 PM- a Game (5th Sunday); *3:00 PM- Bingo, Crafts, a Music program (2 occasions), a Game, Resident Council, or a Movie (Monday-Friday); and *6:30 PM- Girl Scout Carolers (3rd Wednesday). The calendar also contained activities without times for LDS Church visit for 3 Sundays, Catholic &amp; Jehovah Witness Visit every Thursday,</p>	F 248	<p><b>Center Systems</b></p> <p>The center upholds the need to provide an ongoing program of activities to meet, in accordance with the comprehensive assessment, interests, and physical, mental, and psychosocial well-being of each resident.</p> <ul style="list-style-type: none"> <li>▪ A variety and increased number of opportunities for resident activities are now in place for residents to choose in order to meet their psychosocial needs, including evening and weekend activities as well as more bingo. Monthly calendars are adjusted based on resident desires.</li> <li>▪ Bank duties are reassigned to another employee. In general, time away from activities for activity staff shall be maintained at a minimum.</li> <li>▪ Resident MDS is reviewed on admission and with a change of condition for individual life patterns and choices with a plan developed for an ongoing program of activities to meet the resident current needs.</li> <li>▪ Monthly review of participation records monitor resident involvement and determine where adjustments to the plan of care are indicated.</li> </ul> <p>The Executive Director (ED) and SDC has re-educated activity staff to create programming that is relevant to specific needs, culture, and background of each individual including large and small group, one-to-one, and self directed activities. Clinical staff was trained to understand their role in provision of an appropriate and successful activity program. Additional activity staff education for care of the resident with dementia is scheduled.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(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 248	<p>Continued From page 7 and Beauty Shop every Tuesday.</p> <p>The January 2014 activities were: *10:00 AM- Coffee and either Donuts or a game or reading activity (Sunday-Friday); *10:00 AM- Walmart (4th Thursday); *11:00 AM- Exercise Group (Sunday-Saturday); *12:00 PM- Lunch Social (Sunday-Saturday); *2:00 PM- Parma Revival (2nd &amp; 4th Sunday); *2:30 PM- Nails or Beading Group (1st &amp; 3rd Sunday); *3:00 PM- Bingo, Crafts, a Music program (1 occasion), a Game, a Movie, Resident Council, or Snack Cart (Monday-Friday). The calendar also contained activities without times for LDS Church visit for 3 Sundays, Catholic &amp; Jehovah Witness Visit every Thursday, and Beauty Shop every Tuesday.</p> <p>Note: New Years Day (1/1/14) documented Leisure Time all day with no other activities listed.</p> <p>The February 2014 activities were: *10:00 AM- Coffee and either Donuts or a game or reading activity (Sunday-Friday); *10:00 AM- Walmart (3rd Wednesday); *11:00 AM- Exercise Group (Sunday-Saturday); *11:15 AM- Golden Coral (1st Tuesday); *12:00 PM- Lunch Social (Sunday-Saturday); *2:00 PM- Parma Revival (2nd &amp; 4th Sunday); *2:00 PM- Movie Trip (4th Wednesday); *2:30 PM- Dazzling Nails or Beading Group (1st &amp; 3rd Sunday); *3:00 PM- Bingo, Crafts, a Music program (2 occasions), a Game, a Movie, Resident Council or Snack Cart (Monday-Friday). The calendar also contained activities without times for LDS Church visit for 3 Sundays, Catholic &amp; Jehovah Witness Visit every Thursday,</p>	F 248	<p><b>Monitor</b> The ED and/or designee will review activity calendar once per month for 3 months to validate adequate and appropriate activities are offered. In addition, the ED and/or designee will validate that activity plans and participation are reflective of the resident desires. Four resident activity records will be reviewed and 4 residents will be interviewed weekly for 4 weeks, then 2 resident activity records reviewed and 2 resident interviews will be interviewed weekly for 4 weeks. Starting the week of March 17, 2014, documentation will take place on the PI Audit Tool. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p> <p><b>Date of Compliance</b> March 21, 2014</p>	

*updated John Schulties*  
*JSM*  
Exec Dir  
Director  
4/3/14

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 248	<p>Continued From page 8 and Beauty Shop every Tuesday.</p> <p>The activity for Lunch Social was observed on 2/11 and 2/12/14 in both the Rose and Paradise dining rooms. However, during these observations there were no activity staff present and the staff who were there were only observed assisting residents with their lunch trays and drinks.</p> <p>During the resident Group Interview on 2/11/14 at 10:00 AM, residents were asked about the facility's activity program. Six of the 15 residents in attendance said they wanted more activities in the evening, because after the activity at 3:00 PM, the only thing to do was to play board games on their own. Near the end of the group discussion, one resident asked when the coffee and donuts were going to be there. The surveyor did not know about the coffee and donuts, but another resident said they would be there when the surveyors were finished and said it is the one activity the resident's looked forward to.</p> <p>On 2/11/14 at 2:58 PM, three residents from the Group Interview were asked if the surveyor who led Group Interview interrupted their coffee and donuts activity for that day. The three residents said the issue was brought up the day before in Resident Council meeting and the group decided it would be alright to have the coffee after the surveyors were done. They were also asked about calendar variety and one resident said the calendar was, "Pretty much the same." Two of the 3 residents said they would like more bingo added to the calendar.</p> <p>On 2/12/14 at 7:05 PM, a resident who wished to remain anonymous was asked if the facility</p>	F 248			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 248	<p>Continued From page 9</p> <p>provided activities at night and the resident stated, "No, but it would be nice."</p> <p>On 2/12/14 at 7:10 PM, CNA #26 was interviewed about what activities were offered during the evenings. She stated, "Not on night [shift] they really don't, just TV."</p> <p>On 2/13/14 at 1:30 PM, the Activity Director [A.D.] was interviewed regarding the activity issues. When asked what the Saturday Afternoon Leisure Time activity was, she stated, "They [residents] do whatever they want." She explained her assistant is only given 30 hours a week and he leaves at noon on Saturdays. She said the assistant would stay longer if he was given more hours, but the budget won't allow it. When asked why there were no evening activities, she said many residents liked to go bed after dinner and some nurses and the DON liked to have the residents go to be after dinner. She said residents had puzzles and games in the lobby area available to them if they wanted. When asked if she had come at night to see if nursing staff were assisting residents with puzzles or games, she said she had come in, but did not see nursing staff assisting the residents with the activities. When asked about the Lunch Social activity, she said the activity was when staff interacted with the residents and socialized prior to lunch service. When the surveyor informed her the staff were observed performing lunch set up only, she said she is not able to be there to make sure socializing occurred because, "During lunch social we are going to the bank," making facility deposits and other errands for the facility every day.</p> <p>On 2/13/14 at 3:00 PM, the Administrator was</p>	F 248			

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605	
(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 248	<p>Continued From page 10</p> <p>interviewed and asked about the A.D. and A.D. assistant hours and duties. When asked how many staff the Activity program had, he said "one and three quarters" because, "That's what we have in our budget." When asked who set the budget he stated, "Corporate." When asked why the activities staff makes facility deposits, he said the facility deposits needed to be done by someone outside of the business office, due to a segregation of duties. When asked why the A.D. specifically did this, he stated, "She's just been the one doing it." When asked if the time the A.D. went to the bank was considered activity time or business office time, he said the hours were charged to the activity program.</p> <p>On 2/13/14 at 3:30 PM, the Administrator informed the surveyor the A.D. was also a bank signer for petty cash for the facility, which was one reason she went to the bank.</p> <p>2. Resident #5 was readmitted to the facility on 10/1/11 with multiple diagnoses including dementia without behavioral disturbances and depression.</p> <p>The resident's quarterly MDS Assessment, dated 11/21/13, documented the resident: *had a BIMs of 0, which indicated severe cognitive impairment; *wandered 1 to 3 days; *required total assistance with two persons for transfers.</p> <p>The resident's care plan documented, in part: 8/2/13-Focus of, "[Resident] has an impaired communication problem r/t [related to] dementia." With one of the interventions of, "Provide a program of activities that accommodates the</p>	F 248		

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 248	<p>Continued From page 11</p> <p>resident's communication abilities." -Focus of, "[Resident] has limited physical mobility r/t dementia..." With one of the interventions of, "Develop one-on-one visits with topics of interest." -Focus of, "[Resident] is an elopement risk/wanderer..." With one of the interventions of, "Provide structured activities:...reorientation strategies including signs, pictures and memory boxes."</p> <p>9/20/12-Focus of, "[Resident] attends activities of interest/choices and engages in self-initiated leisure activities." With one of the interventions of, "Invite, encourage and assist as needed to activities of choice..."</p> <p>10/1/12-Focus of, "[Resident] has impaired cognitive function r/t Dementia, depression, very HOH [hard of hearing], vision compromise." With one of the interventions of, "Engage [Resident] in simple, structured activities that avoid overly demanding tasks. Res[ident] favored activity is getting his back rubbed."</p> <p>The resident's Monthly Activity Summary sheets were reviewed for December 2013-February 10, 2014 and documented the following activities the resident participated in: "Socializing" 10 times for December, 18 times for January, and 10 times for February; "Walks/Wheelchair" 14 times for December, 26 times for January, and 10 times for February; "Kids Visit/Family" twice for December; "Coffee Social" once for January and once for February; "Television" 4 times for January and 4 times for February; "Snack Cart" 2 times for January;</p>	F 248			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 248	<p>Continued From page 12</p> <p>"Music" and "Ice Cream" once for each for February; and "Bingo" once for January; Note: There were no one-on-one or back rubbing activities noted or recorded on the Activity Summaries.</p> <p>The resident's most recent Activities Progress Notes were dated 8/21/13 and documented, "(Quarterly) Resident continues to be stable. He is alert and oriented with confusing [sic]. He likes to wander around the building. He wanders into music groups, church activities, and we also give him a snack when he is in the hall. His family does occasionally come in and visits. Will proceeded [sic] on his careplan to maintain his goal."</p> <p>During the survey, the following observations were made: *2/10/14 1:24 PM-The Resident was sitting in his wheelchair, in his room, drifting in and out of sleep; 3:00-3:07 PM-The Resident was in his wheelchair, in his room, taking medications from LN #2 and was adjusted in his wheelchair by CNA #1, neither of them were observed rubbing his back; and 4:12 PM-The Resident was in his wheelchair asleep, in his room. *2/11/14 9:12 AM-The Resident was awake in his wheelchair, out side of his room in the hallway; 9:43 AM-The Resident was sitting in his wheelchair, in his room drifting in and out of sleep; 11:59 AM and 4:08 PM-The Resident was sitting in his wheelchair, in the hallway outside of his</p>	F 248			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 248	<p>Continued From page 13</p> <p>room, drifting in and out of sleep; and 11:02 AM, 2:00 PM, and 3:17 PM-The Resident was asleep in bed.</p> <p>*2/12/14 1:25 PM-The Resident was awake sitting in his wheelchair, in his room; and 2:10 PM and 6:45 PM-The Resident was asleep in bed.</p> <p>On 2/11/14 CNA #7 was interviewed regarding the resident's daily routine and activities. She said he sits in his wheelchair and wanders up and down the hallway, naps in his wheelchair or bed, staff will talk to him, and sometimes staff reads letters from family to him.</p> <p>On 2/13/14 at 1:55 PM the Activity Director (A.D.) was interviewed regarding the resident's activities. When shown the last activity progress note was on 8/20/13, she stated, "Why haven't I charted on this poor guy?" When asked to define the 'Socializing' activity, she said it was when the resident talked with staff in the hallway or when he stopped by staff offices. When asked to clarify the 'Walks/Wheelchair' activity, she said it was when the resident was seen wandering in the facility or when he wandered into activities. When asked about the lack of one-on-one activities, she said she did them sometimes, but they were not documented.</p> <p>When asked if she tried activities which were specifically designed or geared towards residents with dementia, the A.D. said she had tried to get the resident involved in working with colored blocks and music instruments, but those did not work. When asked if she had tried any sensory stimulation activities, she stated, "No, he sleeps a lot." When asked if she had any training or researched how to provide activities for residents</p>	F 248		

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 248	<p>Continued From page 14</p> <p>with dementia, she said she had attended a local health care conference last summer but stated, "I probably do need more education on dementia."</p> <p>On 2/13/14 at 4:35 PM the DON and DDCO were interviewed regarding the resident's activities. When asked if nursing staff knew about the care plan intervention to rub the resident's back, the DON said they do rub his back and stated, "Do you want me to go rub his back right now?" The DON said the resident voiced loud verbal appreciation when his back is rubbed. Note: During every noted observation above, staff did not rub the resident's back. The surveyor only heard the resident one time verbalize a loud sound, but the surveyor was down the hallway making other observations at the time.</p> <p>3. Resident #8 was admitted to the facility on 2/19/06 with diagnoses that included, senile dementia, osteoarthritis and depressive disorder.</p> <p>The resident's Annual MDS, dated 7/3/13, documented:</p> <p>*BIMS (Brief Interview for Mental Status): 3- severely impaired cognition *Interview for Activity Preferences: -F. How important is it to you to do your favorite activities?: "Very Important."</p> <p>The resident's Quarterly MDS, dated 11/14/13, documented: *BIMS: 1-severely impaired.</p> <p>The resident's Pleasant and Meaningful Activities assessment dated 5/22/08, documented: *Enjoys now: Listening to music, Watching Television, Massage, Being alone, Reminiscing.</p>	F 248			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 248	<p>Continued From page 15</p> <p>The Resident's Abilities-Focused Activities Assessment dated 5/22/08, documented: *Present strengths: -"Responds to touch (rough, smooth, hot or cold)." -"Responds to smell (flowers, onions, baby lotion)." -"Responds to sight (watches people, objects)." -"Responds to sounds of bells, drums, horns." NOTE: This was the most recent activity assessment provided during the survey, for the resident.</p> <p>The resident's Care Plan documented: *Focus: "[Resident's name] is dependent on staff for activities, cognitive stimulation, social interaction r/t (related to) physical limitations, immobility. Date initiated: 9/23/12, revision on: 9/23/12 *Interventions: -"All staff to converse with resident while providing cares." Date initiated: 9/23/02. -"[Resident's name] needs assistance/escort activity functions." Date initiated: 9/23/12. _"When [resident's name] choose[sic] not to participate in organized activities, turn on TV, music in room to provide sensory stimulation and she does enjoy back rubs." Date initiated: 9/23/12, Revision on : 11/17/13.</p> <p>The resident's IDT (Interdisciplinary) Note dated 11/17/13 at 10:25 am, documented: *Type: Activities Note: "[Quarterly] Resident continues to be stable. She is alert and oriented. [Resident] attends [sic] to sleep a lot in her bed and while she is in her chair. When she is awake she does enjoy back rubs, and music, her husband [Husbands name] does go down to see</p>	F 248			

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

PRINTED: 03/03/2014  
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  C <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 248	<p>Continued From page 16</p> <p>her occasionally. Her daughters are active in her life. Will proceed on her care plan to maintain her goal."</p> <p>The resident's Monthly Activity Summary dated January 2014, documented:</p> <p>*Activities:</p> <ul style="list-style-type: none"> <li>-Socializing : The resident actively participated 18 days of the month, and passively participated 6 days. The resident slept 2 days, and slept/ participated 1 day of the month.</li> <li>-Walks/wheelchair: The resident actively participated 18 days of the month, and passively participated 6 days. The resident slept 5 days of the month.</li> <li>-1 on 1: The resident had 2 days with 1-on-1 provided.</li> <li>-There were no days that back rub or massages were provided, and no activities provided on "New Years," January 1st.</li> </ul> <p>The resident's Monthly Activity Summary, dated 2/1/14 through 2/12/14, documented:</p> <p>No activity was provided to the resident on 2/1/14. There were no days the resident had a 1-on-1 program, and no days the resident had a back rub or massage.</p> <p>On 2/11/14 at 8:35 am, the resident was observed in her w/c in her room sitting in front of the TV. The resident was not watching TV. The resident was trying to figure out how to get a hold of staff she needed to go to the bathroom, and her call light was not in reach.</p> <p>On 2/11/14 at 9:38 am through 10:00 am, the resident was observed a sleep in her w/c sitting in</p>	F 248		

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 248	<p>Continued From page 17 front of her TV.</p> <p>On 2/11/14 at 11:03 am, the resident was sitting in her w/c in the hallway by the door to her room, no interactions were observed.</p> <p>On 2/11/14 at 12:45 am, the resident was observed with her eyes closed, in her w/c by the door to her room, moaning.</p> <p>On 2/13/14 at 9:25 am, the AA (Activity Aide) was interviewed about the activity program, and stated Resident #8's socializing consisted of time drinking coffee and talking. The AA stated the resident's "passive times" indicated Resident #8 was not actively involved in conversations, while the "active times" indicated the resident was engaged in conversation. When asked about the wheelchair/walk activity for the resident, the AA stated, "We will have the aide get her up for [something] like a walk or out in the wheelchair to get her out of the room."</p> <p>On 2/13/14 at 2:30 pm, The AD was interviewed concerning Resident #8's activity program. The AD stated, "Socializing is the resident coming and sitting with us, she doesn't participate any more. She does like cream and sugar in her coffee, and will drink that." When the AD was asked about providing a 1-on-1 program for the resident, the AD stated, "We do not; I have a lot to work on with her." When asked how a resident with dementia would know about activities and get there, the AD stated, "The staff should help us get her there." When asked about back rubs and massages for the resident, the AD stated, "[Resident's name] does like that. She likes rubbing of her arms, but we haven't done that in a long time."</p>	F 248	<p style="text-align: right;"><b>RECEIVED</b> <b>APR - 3 2014</b> <b>FACILITY STANDARDS</b></p>	

*updated for* Executive Director  
4/3/2014

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605	
(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 248	Continued From page 18 On 2/13/14 at 6:15 pm, the Administrator, DON and DDCO, were informed of the concerns. No additional information was provided.	F 248		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interview, it was determined the facility failed to ensure the ice machine in the 200 hallway was kept in good repair. This was true for Random Resident (RR) #17, and any resident accessing the 200 hall ice machine. The deficient practice had the potential to cause more than minimal harm if RR #17 fell while trying to retrieve broken parts from the ice machine from the floor. Findings included:  On 2/11/14 at 12:15 PM, the surveyor observed an ice machine in the 200 hallway, accessible to and in full view of facility residents. The ice machine had dispensers for both ice and water. The dispenser for the water was covered with a clear plastic sleeve; the dispenser for the ice had a bracket for the same sleeve to be present, but the sleeve was missing. RR #17 approached the surveyor and stated the protective sleeve for the ice dispenser had been missing for 3 weeks. The resident stated she had looked for it everywhere, even on the floor near and underneath the ice dispenser, but had been unable to locate it. The resident stated, "I guess it will eventually turn up."	F 253	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.  F 253 <b>Resident Specific</b> The ice machine was removed from a resident accessible area. Staff assist resident # 17 with ice.  <b>Other Residents</b> Staff assists residents with ice routinely and upon request.	

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>C</b>  <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 253	<p>Continued From page 19</p> <p>The resident demonstrated how she used her bare hand to access the ice dispenser and obtain ice. NOTE: Please see F 441 as it pertains to infection control.</p> <p>On 2/12/14 at 6:55 PM, the surveyor again observed the ice machine. The protective sleeve for the ice dispenser was still missing. RR #17 again approached the surveyor, and stated she had been looking for the protective sleeve since the previous conversation, with no luck. The resident bent over in her wheelchair and attempted to visualize under the ice machine to find the sleeve. The resident stated, "It comes off all the time. Usually I just pick it up and put it here (gesturing to the overflow rack on the ice machine) until I'm ready to use it. I guess it's good and gone this time."</p> <p>On 2/13/14 at 2:25 PM, the Maintenance Director was asked about the missing sleeve from the ice dispenser. The Maintenance Director stated, "I know. It's just disappeared." The surveyor informed the Maintenance Director of the above observations. The Maintenance Director stated, "I'll have to order it. I don't just have another one laying around. They cost \$135."</p> <p>On 2/13/14 at 6:30 PM, the Administrator, DNS, and DDCO were informed of the surveyor's findings. The facility offered no further information.</p>	F 253	<p><b>Center Systems</b></p> <p>The ED and/or SDC has re-educated staff and the Maintenance Supervisor regarding completion of work orders, out of service options for equipment, and timeliness of repairs. The center ice machine has been moved to eliminate potential for unsupervised use by residents. Staff assists residents with ice routinely and upon request. The Maintenance Supervisor maintains the equipment in a safe and sanitary fashion. Regular rounds with the ED, as well as scheduled preventative maintenance tasks are performed on the building and equipment. This shall include but not be limited to, any ice machine and replacement of the clear plastic protective sleeve.</p> <p><b>Monitor</b></p> <p>The ED and/or designee will round weekly for 8 weeks to validate proper maintenance and upkeep of the ice machines, as well as work order completions and timeliness of repairs. Starting the week of March 17, 2014, documentation will take place on the PI Audit Tool. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p>	
F 309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,</p>	F 309	<p><b>Date of Compliance</b> March 21, 2014</p>	

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

PRINTED: 03/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 20</p> <p>mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to:</p> <ul style="list-style-type: none"> <li>*Ensure a resident received necessary emergency medical treatment and services after sustaining multiple second and third degree burns;</li> <li>*Recognize and evaluate a resident for fracture who had unusual movement in a previously immobile arm, and increased reporting of pain to the arm;</li> <li>*Provide appropriate and timely treatment for an arm fracture and notify the physician of the delay;</li> <li>*Ensure residents with edema had TED (Therapeutic Embolic Device) hose in place as well as geri sleeves for bruising as indicated by Physician Orders; and</li> <li>*Implement a care plan for falls upon admission for a resident with a known fall history.</li> </ul> <p>Resident #1 was harmed when she was not sent to the Emergency Department for evaluation of multiple second and third degree burns as is indicated in the facility's burn policy and was not seen by a physician for 6 days following the incident.</p> <p>Resident #4 was harmed when he was not evaluated for a fracture following an increase in abnormal movement and pain to the effected arm and received delayed and inappropriate treatment for the fracture when it was identified.</p> <p>This was true for 4 of the 15 (#'s 1, 4, 8 and 10) sampled residents reviewed for Quality Care</p>	F 309	<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 State Form 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><b>F 309</b> <b>Resident Specific</b> Resident # 1 and 4 were self reported to the Bureau of Facility Standards prior to survey. Both residents had been seen by the physician and had care updates prior to the survey entrance. Clinical staff reviewed resident # 8 was reviewed for use of TED hose and geri-sleeve. Plan of care is updated as indicated. Resident # 10 had discharged prior to survey.</p> <p><b>Other Residents</b> Clinical Management team reviewed residents with accidents, injuries, and/or significant changes for timely emergency medical treatment by a physician. No other delays in treatment were identified.</p>		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605	
(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 309	<p>Continued From page 21 issues. Findings include:</p> <p>1. The facility's Health Care Burns policy dated 04/28/09, documented in part: "First and second degree Burns ...3. Immerse in cool water or apply cool moist saline packs as soon as possible. ...5. If second degree burn, immerse area in cool water or apply moist saline compresses immediately until the employee no longer feels a burning sensation when the area is exposed to air. Irrigate gently to remove all loose dirt and skin. ...6. Apply dry sterile dressing or apply a thin layer of Silvadone (silver sulfadiazine) with a dry, sterile dressing to reduce inflammation... Third degree burns/Extensive Burns ...13. Refer extensive second degree burns or third degree burns for medical care immediately... ...14. Arrange for immediate emergency transportation and medical care for any extensive third degree burn. ...15. Do Not remove clothing that adheres to burned tissue. ...20. Do NOT apply any medications to burns."</p> <p>Resident #1 was admitted to the facility on 2/22/12 with multiple diagnoses which included falls, stroke, COPD (Chronic Obstructive Pulmonary Disease) and malnutrition.</p> <p>Resident #1's Quarterly MDS assessment dated 12/6/13, documented the resident: -Had a BIMS of 12, indicating the resident was cognitively intact; -Required extensive assistance of one person for bed mobility and transfer; -Was frequently incontinent of urine; and</p>	F 309	<p><b>Center Systems</b> SDC, DNS, and/or District Director of Clinical Operations (DDCO) have educated licensed nursing staff regarding necessary care and services to include but not limited to,</p> <ul style="list-style-type: none"> <li>▪ Emergency medical treatment and services by a physician for burns, unusual movement of a limb, and localized pain.</li> <li>▪ First aid for burns.</li> <li>▪ Physician notification regarding delay in supplies or inability to carry out physician orders requires physician update and directives documented.</li> <li>▪ Care plans are initiated on admission for imminent risk areas.</li> <li>▪ Physician orders are to be carried out timely and consistently to include but not limited to, TED hose and geri-sleeves.</li> </ul> <p>Care and services are reviewed through shift-to-shift clinical report, daily clinical management meeting, chart audit, and clinical rounds. Consideration and decision making regarding emergent treatment is part of the post-event interdisciplinary review.</p>

updated *Johnfall* - Executive Director  
4/3/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 22</p> <p>-Had a fall since admission with no injury.</p> <p>The resident's Care Plan included a focus area documented on 6/17/13, "[Resident] had an actual fall with No injury r/t [related to] Unsteady gait, Poor Balance, recent CVA [cerebrovascular accident]." Goals dated 9/19/13, documented: "[Resident] will resume usual activities without further incident through the review date." Interventions dated 6/17/13, documented: -Continue skilled therapies for strengthening; -Encourage to use call light for assistance; -Monitor/document/report PRN [as needed] x 72h [every 72 hours] to MD [Medical Doctor] for s/sx [signs and symptoms]: Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation; and -Neuro-checks per policy and procedure."</p> <p>The Resident's Incident Investigation Directives Post Fall documented on 11/20/13: -2:20 AM, "Call light was on, CNA entered room [and] found resident on floor beside bed. [sic] Was laying on LT [left] side, with legs under bed. Resident states she rolled out of bed. Denies trying to get out of bed. Interventions included: -Change air mattress [sic] w/th [mattress with the] bolsters; -Neuro [72 hours crossed out]; and -Monitor [sic] pain 72 [hours]"</p> <p>The resident's interdisciplinary progress notes documented: -1/4/14 at 3:44 AM: "At 0205 [2:05 AM], resident found on the floor between bed and window wall. Skin on back is reddened but blanchable. No apparent other injuries from fall. When moving resident she did touch her upper left arm on the</p>	F 309	<p><b>Monitor</b> DNS and/or designee will make rounds 3 times each week for physician ordered implementation of skin, circulation, and/or protection devices, audit nursing communication for timely implementation of emergency medical treatment, burn first aid, physician notification for potential delay in orders implementation, care plan initiation on admission, and implementation of TED hose/geri-sleeve. Residents will be identified for review through clinical report, new orders review, and rounds. Four residents will be reviewed weekly for 4 weeks, then 2 residents weekly for 4 weeks. Starting the week of March 17, 2014, documentation will take place on the PI Audit Tool. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p> <p><b>Date of Compliance</b> March 21, 2014</p>		

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 309	<p>Continued From page 23</p> <p>heater. No red spot noted at this time but will continue to monitor that area for possible burn. ROM [range of motion] within normal limits for resident. Neuro checks within normal limits for resident. BP [blood pressure] elevated but is gradually coming back down. Will continue neuro checks and monitoring per protocol x72hrs [hours]."</p> <p>-1/4/14 at 3:50 AM, "When resident returned to bed with assist, complained of pain in left foot. Aide removed sock to check foot. Found denuded spots on great toe and second toe. Areas white, dry except around edge where skin pulled off by sock. Toes reddened, irritated. Great toe nail black. Areas cleaned, covered with telfa and bactroban, held in place with gauze for protection for the rest of the night. Will request proper tx [treatment] orders."</p> <p>-1/4/14 at 9:38 AM, "L [left] great toe from nail to top of foot about 2inches [sic] is white with top layer of skin missing, great toenail is purple and intact. 2nd toe around knuckle missing skin with purple center and white around edges [sic]. 3rd toe knuckle area has fluid filled blister, skin intat [sic]. Top of foot is red and tender to touch. [MD] notified, new orders to apply silvadene cream, non stick telfa, wrap in gauze, change 1 x [time] daily. Will monitor for s/s [signs and symptoms] of infection, swelling, redness, pain, fever, s/s of healing as well."</p> <p>1/6/14 at 11:09 AM, "IDT review of event on 1/4/14 at 0205 [2:05 AM]. Resident was seen asleep in bed at 0150. At approximately 0205, CNA smelled something burning and found resident with pillow and blanket behind her laying against base board heater. First Aide[sic] initiated. Resident received several burns to left toes and back. She has a swollen left ankle. x-ray</p>	F 309			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 309	<p>Continued From page 24</p> <p>was negative for fracture. See assessments dated 01/05/14. Resident's pain is controlled with Norco. Treatment initiated with blister to rt [right] scapula resolved. Family and MD notified. Bed was moved away from heater. All beds against base board heaters were turned away and contractor will move all base board heaters to the center walls away from the beds. Will monitor and treat until resolved."</p> <p>The resident's Physician Telephone Orders include: -1/4/14:"Paint blister to RT [right] scapula area w/ [with] betadyn. Let air dry. Cover w/ island drsg [dressing]. Change QD [every day]; Paint blister to lateral left back, flank w/ betadyn. Let air dry. Cover w/ island drsg. Change QD; -1/4/14 Clense (L) mid back blister w/ gauze. Swab blister w/ betadine. Cover w/ non-adherent pad change drsg [dressing] daily. If blister sloughs follow w/ drsg treatment for (L) toes; and -1/8/14 Clense (L) foot w/ NS [Normal saline]. Pat dry w/ gauze apply betadine. Air dry. Weave interdry cloth between toes. Apply exudry to large area of top of foot. Secure w/ kerlix. Change daily and prn [as needed]."</p> <p>A facility Incident Investigation Directives Post Fall was undated, documented the following: "Summary of Event: CNA heard someone calling for help. Search rooms and found [resident] had rolled off the back side of her bed onto the baseboard heater. LN [licensed nurse] assessment identified open areas, first aide provided and MD notified for orders.... Immediate Interventions: -Bed turned away from heater and window to provide distance.</p>	F 309		

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 309	<p>Continued From page 25</p> <ul style="list-style-type: none"> <li>-Wound treatment initiated.</li> <li>-Pravalon Boot to left foot and keen wedge to float both heels.</li> <li>-1/4 rails bilaterally to assist with bed mobility.</li> <li>-Foot cradle to elevate bedding.</li> <li>-Monitoring for increase pain and medicate as ordered.</li> <li>-Continue with air mattress and off load area's affected.</li> <li>-Neuro's initiated</li> </ul> <p>Investigation and Conclusion: Upon completion of a thorough investigation including resident interviews, observation, and record reviews it is determined that [resident] moves around in her bed. At approximately 0130 she was provided cares and repositioned in the middle of her bed with her call light. Around 0150 the LPN observed [resident] curled in a fetal position on her bed with her call light. [Resident] states she rolled out of her bed by the window and became stuck between the bed and the wall heater. She states that it was hot and she called for help.</p> <p>One CNA reports that she heard someone call for help, but then did not hear anything more. She went to the nurse's station to see if anyone else had heard anything. simultaneously, another CNA was at the time clock checking out for lunch at 0205 when he smelled something burning. The two CNA's heard [resident] call out and found her lying on the floor on her right side with a blanket and pillow between her and the baseboard heater.</p> <p>They moved the bed away from [resident] and called for the LN. The blanket and pillow had scorched marks. The resident gown and socks did not have any evidence of burning. The LN assessed [the resident] with the following: -left great toe nail appeared busied with the top</p>	F 309			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 309	<p>Continued From page 26</p> <p>missing and white like dry patch [sic] -2nd toe had denuded area -left lower back with reddened blanchable area -no blisters noted at this time MD was notified and wounds treated as indicated At approximately 0600, two LN's completed an additional skin check with burns advancing as following [sic]: -left great toe and left 2nd toe open areas -blisters to left 3rd and 4th toes -blister to left rear iliac crest and right scapula -open blister to left lower mid back and mid spine area. MD was updated and orders received. [The resident] complained of left ankle pain. X-ray ordered and results were negative. In Conclusion, it is determined that [the resident] received a variety of burns after she rolled out of bed and onto the baseboard heater. Plans to Prevent Reoccurrence: -All beds next to base board heaters were turned to provide more distance. -Contractor is moving all base board heaters from under the window and way from the resident beds."</p> <p>On 01/10/14 the Physician Progress Note documented, in part, the following: "...now they are applying Betadine to her burns, letting it air dry between her toes, applying Exu-Dry to the large area on the top of her foot and wrap with Kerlix with acetic acid soaks to the left foot daily for 10 minutes. On her back wound they are cleansing it with normal saline, patting it dry, applying Betadine and Accudry and an Exu-Dry, secured with Long Island dressing, changed daily and p.r.n. She does have a foot cradle in place and a Keen wedge...</p> <p>PHYSICAL EXAMINATION:... The top of the left</p>	F 309		

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 309	<p>Continued From page 27</p> <p>great toe including the entire top of the toe has a third-degree burn. There is yellow eschar present in the wound base. There is also a burn on the DIP [Distal interphalangeal joint] ...</p> <p>ASSESSMENT: 1. Fall with 2nd and 3rd degree burns to the back and left foot due to contact with floorboard heater."</p> <p>On 2/10/14 the Physician ordered a wound clinic referral.</p> <p>NOTE: The resident experienced a delay in treatment when she was not immediately sent to the emergency room [ER] as indicated by the facility's Burn Policy points 13 and 14. Although the facility was in contact with the physician by telephone, the resident was not evaluated by the physician until six days after the burn occurred.</p> <p>On 2/12/14 at 3:30 PM, The DON and DDCO were questioned regarding the resident's treatment. They were unable to answer questions at that time, but took notes and said they would research the issue.</p> <p>On 2/13/14 at 3:30 PM, the DON and DDCO were questioned regarding care of the resident following the fall which resulted in burns. When asked why the resident was not transferred to a local ER the DON said, "Her pain was controlled, we initiated treatment and x-ray for her complaints about her ankle. We were in communication with [the resident's physician] throughout the day. She said that there was nothing the ER would have done that we couldn't do here... [Resident's Physician] wasn't here, but she did not appear to have burns at first. At first it was only redness, then as the day went on the third degree burns came. You can see that we</p>	F 309		

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 309	<p>Continued From page 28</p> <p>were on the phone getting physician telephone orders through the day."</p> <p>Additional information was received from the facility on 2/18/14 at 3:17 PM. However the information provided did not resolve the concern.</p> <p>2. Resident #4 was admitted to the facility on 4/25/08 with multiple diagnoses which included hydrocephalus with the placement of a VP shunt, right-sided CVA with left hemiparesis, diet controlled DM, osteoarthritis, and chronic pain.</p> <p>Resident #4's (R#4) Significant Change of Condition (SCOC) MDS assessment, dated 10/16/13, coded:</p> <ul style="list-style-type: none"> <li>-Unable to complete BIMS, assessed by staff with severely impaired cognition.</li> <li>-Non-verbal, able to understand simple, basic, direct information.</li> <li>-Dependent on 2 persons for transfers and dressing.</li> <li>-Did not ambulate.</li> <li>-Pain present, treated with routine pain medication. No PRN medication medications needed. No non-medication pain relief measures used.</li> <li>-Resident unable to rate pain per pain scale, but was not noted with non-verbal signs of pain.</li> </ul> <p>Resident #4's most recent SCOC DS, dated 1/16/14, coded:</p> <ul style="list-style-type: none"> <li>-Unable to complete BIMS, assessed by staff with severely impaired cognition.</li> <li>-Non-verbal, able to understand simple, basic, direct information.</li> <li>-Dependent on 2 persons for transfers and dressing.</li> <li>-Did not ambulate.</li> <li>-Incontinent of bowel.</li> </ul>	F 309		

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 309	<p>Continued From page 29</p> <p>-Foley catheter in place for urine. -Pain present. Both routine and PRN pain medications needed, as well as non-medication pain interventions. -Non-verbal sounds, facial expressions, and protective body movements indicating pain present noted.</p> <p>On 12/23/13, time documented as, "AM," a facility "Stop and Watch Early Warning Tool" documented R #4 was experiencing increased pain. The form was signed by CNA #3, and documented as given to LN #4. LN #4 signed acknowledgement of the document on 12/23/13 at 9:30 AM.</p> <p>Resident #4's Nurse's Progress Notes documented: -12/23/13 at 10:36 AM. Health Status Change (SBAR) [Situation, Background, Assessment, and Request]. Situation: Res has a diagnosis of L [left] hemiparisis [sic]. Background: Res is having more movement with his L upper extremity. Also, res is having increasing pain at L upper extremity. Res is on routine Tylenol 650 mg [milligrams] tid [three times daily], also he has a prn [as needed] dose of Tylenol 650 q [every] 6 hours prn. The routine dose of Tylenol is helpful. Assessment:...No skin issues noted to LUE [left upper extremity]...Request: Please advise." -12/23/13 at 5:33 PM. "New orders received for Ultram." -12/24/13 at 11:58 PM, "zero signs of pain or discomfort." -12/25/13 at 9:31 AM. "X-Ray ordered of L shoulder, L clavicle to rule out fracture. Assessment of resident reveals guarding to L shoulder ROM. Very faint old yellow bruises on upper arm, appear to be 1-2 weeks old. Pt</p>	F 309			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 309	<p>Continued From page 30</p> <p>[patient] with contracted left arm, held to body, when moved he grabs our hand/arm with his right hand and grimaces. [Physician] notified. X-ray to be obtained today to r/o [rule out] fx [fracture], as well as pt has pain medications to be used as needed that control pain per nursing staff report."</p> <p>-12/25/13 at 11:01 AM, "Notified by radiology tech that there is some type of fracture on this resident...Report on fax machine states 'acute proximal left humeral fracture', calls out to [physician], left two messages 11:17 at this time..."</p> <p>-12/25/13 at 11:08 AM, "Late entry for 12/24...It was brought to my attention by CNA that he [R #4] was guarding his left arm. I assessed arm and upper arm is tender and when arm is raised he tries to swing at me with his right arm. Alerted the nurse who said it has been addressed and also notified the charge nurse..." NOTE: There was no entry from either the LN caring for R #4, or from the charge nurse, regarding this report on 12/24/13.</p> <p>-12/25/13 at 11:12 AM. Called to residents [sic] room to assess left arm again, today a yellow discolored area was noted to left upper arm above the elbow and area is still very tender and again tried to swing with his other arm at this nurse. Floor nurse and charge nurse notified."</p> <p>-12/25/13 at 2:22 PM, "When I arrived I was informed of resident having a change in his pain medication due to arm being painful. When I questioned staff they told me it had been this way since it was noted on Monday [12/23/13]. When I went to see it I noticed a faint bruise on outer back upper arm. Supervisor was called by CNA to look at it and that was when an X-ray was ordered..."</p> <p>-12/25/13 at 11:36 PM, "...pain pill given at this time to help relieve pain with next change and</p>	F 309			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 309	<p>Continued From page 31</p> <p>cares, has left arm and sling in place..."</p> <p>-12/26/13 at 2:50 PM, "It was noted at noon today that resident appeared to be in pain. On evaluation of pain MD was called and Ultram 50 [milligrams] [by mouth] was increased to TID from BID [twice daily]..."</p> <p>12/27/13 at 11:08 AM, "...No signs of pain at this time noted...Tightens up when anyone touches left arm..."</p> <p>-12/27/13 at 3:56 PM, "...Resident also with DX [diagnosis] of Left Humerus fx 12/25/13. Sling and swathe [sic] in place, pain medications adjusted to maintain comfort. [Physician] rounded on resident today, no new orders. Resident is pending appointment with ortho[pedic doctor]..."</p> <p>NOTE: This was the first documented physician's examination since the onset of pain and passive mobility changes on 12/23/13, and the diagnosis of the left arm fracture on 12/25/13.</p> <p>12/31/13 at 3:18 PM. "Pt returned from...(ortho) with illegible progress note and order. Multiple attempts made to contact office for clarification made without success r/t holiday. Contacted on call ortho for clarification...but wasn't able to clarify order..."</p> <p>On 12/25/13, an "Addendum: Final X-Ray Report" in R #4's medical record documented Exam Type as, "Portable Shoulder Left." Findings documented, in part, "Acute Proximal humeral fracture noted." The addendum documented, "There is minimal osteoporosis."</p> <p>On 12/25/13 at 12:37 PM, a physician's order documented, "Place Pt in a sling and swath, no lifting or movement with the shoulder."</p> <p>Resident #4's MAR for December 2013 documented a "Pain Rating Scale at the Start of</p>	F 309			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 309	<p>Continued From page 32</p> <p>Each Shift" (Scale of 0 to 10, with 0 being no pain and 10 being the worst pain ever felt), as follows: -Days: Score of "0" 12/1/13 - 12/24/13. Score of 10 on 12/25/13, score of 8 12/26/13 - 12/28/13. -Evenings: Score of "0" 12/1/13 - 12/24/13. Score of 9 on 12/25/13 and 12/26/13, score of 4 on 12/28/13. -Nights: Scores of "0" the entire month. NOTE: Please see interviews and notes below, identifying pain as early as 12/23/13.</p> <p>Resident #4's MAR for December 2013 documented an order for the pain medication Ultram 50 mg twice daily initiated on 12/23/13, and increased to three times daily on 12/26/13.</p> <p>A facility "Unusual Occurrence" report for the above fracture, dated 12/25/13, documented, in part: -"Summary of event: On 12/25/13 during cares, resident noted to guard left arm. Licensed nurse examined and noted some faint yellow bruising and swelling, grimacing with gentle touch. Physician notified, x-ray obtained with evidence of acute proximal left humeral fracture." -"Investigation &amp; Conclusion: Upon completion of a thorough investigation including interviews, record review, and observation it is determined that on the morning of 12/23/13 [Resident #4] exhibited guarding and pain with morning cares... [Doctor] notified and Ultram was added for pain management; there were no behaviors of agitation noted...On 12/24/13 [R #4] appeared to have pain managed with the use of Ultram, no grimacing was noted. ...On the morning of 12/25/13, [R #4] showed evidence of additional faint yellow bruising and some swelling to his left arm. The licensed nurse contacted the physician and an x-ray was obtained. X-ray confirms acute</p>	F 309			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 309	Continued From page 33 proximal left humeral fracture...on the morning of 12/23/13 the CNA assigned to care for [R#4]...approached [R #4] to untie his gown, he groaned and used his right hand to hold his left elbow. When asked if he hurt he indicated yes. The CNA notified the nurse...Investigation indicates...arm was fractured between the evening of 12/22/13 and the morning of 12/23/13." -The last 2 pages of the report were entitled, "Compilation of Interviews (CI) held on 12/30/13, 01/01/14, and 01/02/14." The pages contained bulleted summaries of staff interviews related to this event. Interview statements documented, in part: 12/25/13: -LN #6's statement included a nursing progress note ... "A typed interview from LN #6, dated 1/1/14 at 4:30 PM further documented, "I notified [Physician's Name] on 12/26/13 that [R #4's] pain was not controlled, and received a new pain order...[R #4] was resting after pain medication was adjusted." -A hand-written statement from CNA #7 documented, "I was told on the beging [sic] of my evening shift either on Saturday or Sunday [12/21/13 or 12/22/13] that his arm was sensitive and he was pulling away his arm and crying out...I was also informed that he was going to have an X-Ray and after finding out this, I made sure when he was getting his shirt off or changing him we were careful." -LN #12 documented, "Called to room Tue [Tuesday, 12/24/13] to assess resident's pain - arm was very tender with faint yellow bruise. Mentioned to nurse (LN #4) response was, "It's old and has been taken care of...Wed [12/25/13] called back to room by same aide [CNA #3] due to arm still sore. Reassessed old bruising noted	F 309			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 309	<p>Continued From page 34</p> <p>today and more swelling, had [LN #6] look and call RN supervisor to room and we discussed x-ray to [rule out fracture]." [NOTE: This was 2 days after R #4 was initially noted with symptoms of pain, guarding, and increased passive range of motion in an extremity which had been contracted and immobile for over 25 years.] LN #12's typed statement, dated 1/1/14, a week later, documented regarding the 12/25/13 reassessment of R #4, "...the bruise was larger and darker in color, as if the bruise was coming from the inside out."</p> <p>-CNA # 13 documented, "Monday, Dec[ember] 23 rd when I arrived on shift, [CNA #7] informed me that days told her [R #4] was having arm pain [and] was getting X-Rays. That evening [at] about 6:30, while changing his shirt, he pushed our hand away [and] held his left arm, so we stopped removing the shirt." On 1/1/14, a typed statement from this CNA further documented, "We were able to get his shirt off after we lay resident down. We removed his shirt by taking his good arm out of the sleeve first, then over the head, then slid it off the left arm. Resident appeared in less pain once he was laid down. We were able to roll on his right resident side, but he grimaced when we rolled him to his left side..."</p> <p>-On 12/26/13 at 11:20 AM, a hand-written statement from LN #4 documented, "[CNA # 3] reported to this nurse that res[ident's] left arm was more moveable, and that he had pain with this. I assessed res[ident] [left] arm no skin issues were noted. I reported this to [LN # 9]...I typed up an SBAR report, and faxed this to [Physician's name]. I checked back with [LN #9] and she had received new orders...for Ultram. I initiated the first dose...promptly. The pain med was helpful."</p> <p>-On 12/26/13, at an unknown time, a hand-written statement from LN #9 documented, "On Monday</p>	F 309			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 309	<p>Continued From page 35</p> <p>12/24/13 I received a faxed order for Ultram regarding pain for [R #4]. The fax was non-specific about where the pain [R #4] was having so I thought it was generalized discomfort. I wasn't notified of pain until I received this fax. Tuesday 12/24/13 I was notified of a faded green/yellow bruise on his arm which 'looked old'..."</p> <p>-On 12/26/13, unknown time, a hand-written statement from CNA #10 documented, "Tuesday the 24th...[CNA #3] let me know there was something wrong with his arm. I asked what was wrong with it and she took me into his room and kind of showed me. I saw that his arm just above the elbow was fat and on the top of his shoulder there was a dime-sized yellowish bruise...I got [CNA #3] and [Unknown staff person] to help me get him into bed and dressed...[R #4] did get mad and tried to grab at me when we were putting his shirt on."</p> <p>-On 12/27/13 at an unknown time, a hand-written document identified as a "phone interview" with CNA #3 documented, "About 7:00 - 7:10 AM went in room to get resident ready. [The DNS clarified during interview this statement referred to the morning of 12/23/13.] Res grabbed arm [and] grimaced. Thought it was weird that arm more moveable [and] he was definitely in pain. Reported to [LN #4] [and] asked if there were changes with res...Nurse said no, no changes [and] that we'd watch [and] see what was happening. Went back in room and got res up [with second] aide. Res responded to [other unknown staff member] in Spanish yes I hurt. He continued to appear in pain during the shift, nurse said something about [doctor] knowing."</p> <p>-On 1/1/14, a typed statement from LN # 15 documented, in part, "On 12/23/13, at approximately 10:30 AM...[LN #4]...reported to</p>	F 309			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 309	Continued From page 36 me that CNAs were saying [R #4's] Left arm (CVA affected side) was more mobile and showing increased pain...I said an SBAR to [physician's name] sounds like a great idea,,I asked [LN #4] late afternoon if we had received new orders as I was walking by and she said yes...approximately 8:50 PM...[CNA #7] said [R #4] is in a lot of pain, and we couldn't take his shirt off, he was guarding his arm and staff was waiting on x-rays. I told her I did not know anything about x-ray ordered and for her to check with the nurse because he needed to be medicated for pain so they could get his shirt off. Also to ask the nurse about x-ray orders because if he was in that much pain an x-ray might be a good idea...On 12/25/13 at 6:54 AM I received a call from [LN # 20] reporting...[R #4's] pain, he had old yellow bruising, and swelling to the arm and she could not find any documentation on what had been done...I then asked her if an x-ray had been done, she stated no there weren't any x-ray orders. I asked her what he was receiving for pain and she said Ultram. I asked her please make sure [physician] was notified and an x-ray needed to be done that morning...at [12:21 PM] I received a call from [LN #14]...and she informed me [R #4] had a fracture to his left arm...I let her know to check with skilled therapy if a sling was available to immobilize arm. If not to try our vendors...I also asked her to pad under sling/armpit and make sure staff was checking skin Q shift and medicating [R #4] appropriately for pain...At approximately 3:30 PM [LN # 14] called me again to inform me [vendor] had delivered a sling but no one had a swathe [sic] available...contacted...[retailer]...stated they were sold out...at approximately 5 PM...proceeded to [another retailer]...but they were closed...I called the facility and asked the RN to use ace wrap/gauze or a sheet to create	F 309		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 37  one so his arm would be positioned appropriately. 12/26/13 I looked at resident chart to review orders and x-ray results with 'Acute proximal humeral fracture' noted...I asked [LN #6] on hall how [R #4] was and she stated he was still in pain. I asked her to contact [physician] to make more pain medication adjustments to maintain resident comfort..." NOTE: Approximately 44.5 hours had transpired since R #4 was first noted with pain and passive ROM changes and the time the facility obtained an x-ray. Once the resident was diagnosed with a fracture, there was a delay of approximately 4.5 hours between the time the physician ordered the sling and swath, with no movement to the left shoulder, and the time the facility was able to place the sling. There was no documentation the physician was notified of this delay, nor that the facility was having difficulty obtaining the ordered supplies.  On 12/27/13, a Physician's Progress Note from Resident #4's primary care physician documented, "The patient was seen today in followup of some left shoulder pain. I had initially been notified on 12/23/13, that the patient seemed to be having some increased pain to his left shoulder. He has had multiple strokes so he is hemiparetic on that side, but was having problems with some increased discomfort. There was noted to be no signs of injury or reports injury from the staff. [NOTE: The physician's note did not address whether they physician was aware of the sudden changes in the resident's passive mobility with his affected arm, or address this change as a possible sign of injury.]...at that time, I ordered some Ultram to see if he could tolerate that would help. The patient does have a history of becoming over sedated with hydrocodone and other narcotic pain medications. In any case. I	F 309			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 309	<p>Continued From page 38</p> <p>was called again on 12/25/13 indicating that the Ultram was not helping and he was having significantly worse pain and it seemed to be quite problematic [NOTE: The physician's note did not indicate awareness of the increased pain and combativeness noted in the nurse's notes from 12/24/13.]...An x-ray was obtained on 12/25/13, that showed acute proximal humeral fracture.."</p> <p>On 12/31/13, a Physician's Progress Note, identified by the facility as the progress note from R #4's orthopedic consultation documented, "[Recommend] siing for [left] arm." NOTE: This notation was made 6 days after R #4's x-ray results were available, and 8 days after R #4 was originally noted with increased pain and passive movement in his affected extremity.</p> <p>On 2/12/13 at 12:45 PM, the DNS and DDCO were asked about R #4's arm fracture, in terms of his increased pain, and the delay between the onset of pain and diagnosis. The DNS stated the physician was notified of the resident's new onset of symptoms on 12/23/13, and ordered Ultram for the resident's pain. The DNS was unable to state whether or not Resident #4's mobility changes were considered as a symptom, along with his increased pain. The DNS stated she was unsure when the resident had first been evaluated by a physician after the onset of these symptoms, but it could have been that the physician visit at the facility on 12/27/13 was the first time a physician examined the resident after the fracture was discovered. The DNS stated a resident with a new fracture would only be sent out to the hospital or physician's office if the physician ordered it. The DNS was asked about continued reports from the CNAs of the resident continuing to experience pain throughout 12/23/13,</p>	F 309			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 309	<p>Continued From page 39</p> <p>12/24/13, and 12/25/13 when the fracture was diagnosed. The DNS stated the CNAs were expected to report changes to the nursing staff, and the nurse should handle it. The DNS stated she thought the nurses had handled the situation, given their assessments at the time. The DNS was asked if the physician had been notified of the delay in getting the sling and swath placed, so those treatment choices could be re-evaluated. The DNS stated once the physician ordered the sling and swath, the facility staff had proceeded to get them in place. The DNS was asked if the physician had been notified the facility had been unable to locate a swath, and had used an alternate material instead. The DNS stated she would look into it.</p> <p>On 2/13/15 at 10:50 AM, the DNS and DDCO approached the surveyor for further follow-up. The DNS and DDCO stated they had spoken to the resident's physician that morning, and the physician stated at the time the symptoms of pain appeared, and even when the fracture was diagnosed, it was not felt the resident needed to be evaluated further outside the facility, until an orthopedic appointment could be made. The DNS and DDCO also stated the physician had been unaware of the substitution of another material for the swath until the resident was examined on 12/27/13, but was not concerned the substitution had been made.</p> <p>Resident #4 was harmed when he sustained a fracture in the facility, which was not diagnosed for at least 2 days after the onset of increased pain and mobility changes. Resident #4 continued to experience pain and distress during cares throughout this time. Further, once the fracture was diagnosed, there was a delay of several</p>	F 309			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 309	<p>Continued From page 40</p> <p>hours before the supplies for treatment, as ordered by the physician, could be obtained.</p> <p>On 2/13/13 at 6:30 PM, the Administrator, DNS, and DDCO were informed of the surveyor's concerns. The facility offered no further information.</p> <p>3. Resident #10 was admitted to the facility on 2/8/13 with multiple diagnoses which included a history of syncope with falls.</p> <p>No MDS had been completed for Resident #10 by the time of the resident's fall on 2/10/14, the date of the incident in question.</p> <p>Resident #10's History and Physical from the acute care hospital just prior to her admission to the facility, dated 2/3/13, documented, "...presenting to the emergency room with several weeks' worth of events where she falls and almost passes out ... since then, the patient has been experiencing frequent falls and near syncopal events...she notices that she suddenly feels dizzy and faints...her legs then 'give out' and the patient falls to the ground unless she is able to hold on to something ... these episodes appear to be more frequently and as of late almost every other day ... when the symptoms occur, they appear to be without a discernable pattern ..."</p> <p>Resident #10's Morse Fall Risk Scale, dated 2/8/13, documented the resident had a history of falls, with two or more related diagnoses on record, needed an assistive device for ambulation, experienced weakness in her gait, and over-estimated or forgot her limitations.</p> <p>Resident #10's Nurse Progress Notes</p>	F 309			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 309	<p>Continued From page 41</p> <p>documented:</p> <p>-2/8/13 at 5:21 PM. "...Pt arrived from [acute care hospital]...post syncopal episodes with falls...Pt A &amp; O X 4 [alert and oriented to person, place, time, and event]. Able to call using call light... [Complains of] [right] knee pain with ambulation. Pt is generally lethargic [and] has poor balance [and] safety awareness, Advise pt to get up slowly to avoid hypotensive issues..."</p> <p>-2/9/13 at 1:20 PM. "Alert and oriented and makes her needs and concerns known. One person standby assist with ambulation. Limited assist with transfer and toileting.</p> <p>-2/10/14 at 5:41 AM. "[At approximately 4:45 AM] RN was notified Res had fallen..."</p> <p>On 2/13/14 at 1:00 PM, the DNS and DDCO were asked for Resident #10's care plan at the time she fell. On 2/14/14 at 12:00 noon, the DDCO provided a care plan for Resident #10, with a Focus areas related to falls and syncope. However, the initiation date for those areas was 2/11/13. The DDCO stated the facility had not yet developed a care plan at the time the resident fell.</p> <p>On 2/14/14 at 12:05 PM, the Administrator, DNS, and DDCO were informed of the surveyor's concerns. The facility provided no additional information</p> <p>4. Resident #8 was admitted to the facility on 2/19/06 with diagnoses that included senile dementia, osteoarthritis and depressive disorder.</p> <p>The resident's Physician orders dated, 2/1/14 thru 2/28/14, documented: Bilateral knee high Ted Hose on in AM (morning) off at HS (hour of sleep). Dx. (Diagnosis): Edema</p>	F 309			

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

PRINTED: 03/03/2014  
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  C <b>02/14/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 309	<p>Continued From page 42</p> <p>The resident's Non -Pressure Ulcer Investigation report dated 1/17/14, documented: *Skin Issue: "Bruise" *Describe Event: "Assisting pt. (patient) to dining room noticed bruising on the tops of both hands. Pt. denies pain." *PI (Performance Improvement) recommendations: "Geri Sleeves."</p> <p>The resident's care plan documented: *Focus: (Resident name) has an ADL (activity of daily living) self care performance deficit r/t (related to) disease process deterioration in ADL's, declining ability to make decisions. *Interventions: -"Knee High TED Hose on in AM and off at HS."</p> <p>*Focus: (Resident's name) has actual impairment to the skin integrity scratch to right cheek r/t scratching. *Interventions: -"Geri Sleeves."</p> <p>On 2/10/14 at 4:30 pm the resident was observed up in her W/C (wheelchair) with family at her bedside. TED hose were not in place. This was verified with the family member. The family member stated "I don't know why she would need those. She doesn't have any swelling."</p> <p>On 2/11/14 at 8:35 am, the resident was in her w/c in her room. The TED hose were not on the resident. The resident was asked if the staff put stockings on her legs, she stated, "No."</p> <p>On 2/11/14 at 12:50 pm, the resident was in her w/c in the doorway of her room. TED hose and geri sleeves were not in place.</p>	F 309		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 43  On 2/11/14 at 2:00 pm, 2:52 pm and 3:15 pm, the resident was in bed. TED hose and Geri sleeves were not in place.  On 2/12/14 at 12:45 pm, the resident was in her w/c in the dining room. Geri sleeves were not in place.  On 2/12/14 at 1:15 pm, CNA#5 and CNA#19 were observed providing cares for the resident. The resident did not have geri sleeves or TED hose on. CNA#19 was asked if the resident had geri sleeves, and the CNA stated, "No. I have never seen her wear them." CNA#5 was asked if the resident had geri sleeves, the CNA stated, "I don't think so." CNA #5 was asked about the use of TED hose for the resident. The CNA stated, "She does, but she has a sore on her toe so we haven't been putting them on her." When CNA#5 was asked how long it had been since they stopped using the TED hose, the CNA stated, "I think just this week."	F 309			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  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	F 314			

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(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 314	Continued From page 44 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.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review and interviews with staff, residents, and resident families, it was determined the facility failed to implement interventions to prevent the development of pressure sores. This was true for 4 of 5 residents (#s 1, 2, 3, and 4) sampled for pressure sores. *Resident #2 was harmed when she developed a re-current unstageable pressure ulcer on her coccyx while a resident in the facility; *Resident #4 had the potential for more than minimal harm when he developed a Stage II pressure ulcer to his chest and a Stage I pressure ulcer to the left under arm related to the use of a sling after he fractured his arm in the facility; and *Resident #'s 1 and 3 had the potential for more than minimal harm when skin protection interventions were not implemented per their plans of care. Findings included:  1. Resident #2 was admitted to the facility on 9/14/11 with multiple diagnoses including Parkinson's disease, weight loss and dementia.  Resident #2's Quarterly MDS assessment, dated 8/21/13, documented the resident: -Had a BIMS of 1, indicating severe cognitive impairment; -Required extensive assistance of one person for bed mobility, transfer, toilet use, personal hygiene	F 314	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.  F314 <b>Resident Specific</b> Clinical staff reviewed resident # 2 for treatment options and interventions. Care plan is adjusted as indicated and clinical rounds verify implementation. Prior to survey resident # 4 had sling discontinued and wound is healed. ID Team rounds verify that skin prevention devices are in place for resident # 1 and 3.  <b>Other Residents</b> Clinical Management team reviewed residents with wounds, history of wounds, and those at risk per Braden Scale for treatment options and interventions. Care plans were adjusted as indicated and rounds established to verify implementation.  <i>CONTINUE TO PAGE 61</i>		

*PER Phone Conversation  
with Administrator  
on 4/16/14 at 4:00 pm.  
BRAD BERRY*

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

PRINTED: 03/03/2014  
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>C</b>  <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 314	<p>Continued From page 45 and bathing; -Was frequently incontinent of urine; -Had no pressure ulcer and no risk of pressure ulcers; and -Had moisture related skin problems.</p> <p>The resident's Annual MDS assessment dated, 11/21/13, documented the resident: -Had a BIMS of 1, indicating that she was severely impaired; -Required extensive assistance of one person for bed mobility, transfer, toilet use, personal hygiene and bathing; -Was frequently incontinent of urine; -Had 2 stage 1 pressure ulcers and had no other skin problems.</p> <p>The resident's Braden Scale documented on 12/1/13 a score of 17, indicating she was at risk for pressure ulcers.</p> <p>The resident's Non-Pressure Ulcer Investigation on 1/10/14 documented that an open area was found on her coccyx. It documented in part, "Was called to room due to area on coccyx. Checked area [and] instructed staff to apply barrier cream and then reported to supervisor [sic]. Recommendations included: -Treat [and] monitor; -Refer to wound clinic; -Change Q1 hr [every 1 hour] waking; and -Change Q2hr [every 2 hours] Noc [night shift]."</p> <p>The resident's Interdisciplinary Progress Notes documented: -On 1/10/14 at 6:50 AM, "Was called to room to check area on coccyx. On inspection noted open area. Area was on coccyx and open. Had staff apply barrier cream to area and instructed them</p>	F 314			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 314	<p>Continued From page 46</p> <p>to turn and change positions frequently. Then reported to night shift supervisor about the area." -On 1/10/14 at 1:35 PM, "After talking with Supervisor cleaned area and applied Poly mom AG [sic] and a coccyx dressing after Measured and seen by DON and assessed by her. On seeing the area at this time noted the area was larger than first thought." NOTE: See Wound Care Flowsheets below for measurements. -On 1/13/14 at 9:00 AM, "Weekly Pressure Ulcer BWAT [Bates-Jensen Wound Assessment Tool] Report completed. Site information: Coccyx - Pressure: Length = 4.8 [cm], Width = 4.5 [cm], - Stage Unstageable. Date of initial observation: 01/10/2014. BWAT score = 34.0. Continues with Tx [treatment] per MD [Medical Doctor] order for PU [pressure ulcer] on coccyx. Denies pain with Tx. White/Yellow slough noted to base of wound. No s/sx [signs or symptoms] infection. Scant amount of serous drainage on old dressing noted. will monitor. Improvement noted this week See assessment for more details." -On 1/13/14 at 10:37 AM, "IDT review of event on 1/10/14 at 0630 [6:30 AM] and 1200 [1200 PM]. Resident was found with open area to coccyx and buttocks when given cares at 0630. New orders for treatment initiated. Resident dribbles urine constantly. She has a positive U/A [urinalysis] with C&amp;S [culture and sensitivity] pending. Resident set up to change q1 hour during waking and q2 hours during the night..."</p> <p>On 1/17/14 the resident's Physicians Progress note documented in part, "...she was noted to have some ulcers on her bilateral buttocks. The patient does have advanced dementia with Parkinson's disease. She is becoming more immobile and it appears that she had not been turned as a possibility or possibly sat in her chair</p>	F 314		

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

PRINTED: 03/03/2014  
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>C</b>  <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 314	<p>Continued From page 47</p> <p>longer. Most likely it was from her lying in bed in moisture and she has now developed very serious bilateral buttock wounds on the upper buttocks/sacrum. I wanted to evaluate these and write some wound care instructions. The plan is also for her to see the Wound Clinic since it has been very sudden and dramatic onset. The patient is quite debilitated. She is dependent on activities. The patient herself is not able to give me any information...Assessment: 1. New onset bilateral decubitus on the buttocks. 2. Urinary and bladder incontinence. 3. Parkinson's disease with immobility. 4. Dementia."</p> <p>The resident's Wound Care Flowsheets document the following for her coccyx pressure wound: -1/10/14, 4.3 x 4cm, unstageable; -1/13/14, 4.8 x 4.5cm, Butterfly shape, unstageable; -1/20/14, 3.7 x 2.5cm, Irregular shape, unstageable; -1/27/14, 3.0 x 2.3cm, Irregular shape, unstageable; and -2/3/14, 1.7 x 2.0cm, Round/ovai shape, unstageable.</p> <p>The resident's Care Plan included a Focus area for impaired skin prior to the development of her pressure ulcers and was initiated on 9/26/13. The resident Goals documented, "to keep toes free from pressure wounds on feet bilat [sic]. Interventions documented, in part: "-Calmoseptine to buttocks with toileting, initiated 8/12/13; -Geri Sleeves when up, initiated 7/1/13; -Use foot cradle while in bed to keep pressure off of toes on feet bilat [bilaterally], initiated 9/26/13; and</p>	F 314			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 314	<p>Continued From page 48</p> <p>-Use Keen Wedge to float heels, initiated 9/3/13." Note: a Keen Wedge is a triangular foam device that is placed in the residents bed to elevate the feet and float the heels.</p> <p>The resident's Care Plan included a Focus area dated 2/5/14 for her skin problems: "[Resident] has a pressure wound to her buttocks, and a bruise to the top of her left hand." The Goals are documented as, "Keep toes free from pressure wounds on feet bilat, and Wound to buttocks/coccyx will resolve by the review date 1/13/14." Interventions documented, in part:</p> <ul style="list-style-type: none"> <li>-Air flow pad to be used with air mattress for lifting patient up in bed, initiated 1/14/14;</li> <li>-Air mattress to help protect skin, initiated 1/10/14;</li> <li>-Calmosptine to buttocks with toileting, initiated 8/12/12;</li> <li>-Geri sleeves when up, initiated 7/1/13;</li> <li>-Hourly incontinence care to reduce moisture during day, initiated 1/13/14;</li> <li>-Noc shift to provide Q2 hour incontinence care, initiated 1/13/14;</li> <li>-Turn Q2 hours to offload coccyx wound, initiated 2/10/14;</li> <li>-Use foot cradle while in bed to keep pressure off of toes on feet bilat, initiated 9/26/13;</li> <li>-Pt [Patient] not to wear shoes until further evaluation/assessment. Pt to wear socks only, initiated 1/10/14;</li> <li>-Use Keen Wedge to float heels, initiated 9/3/13; and</li> <li>-Wound clinic referral for buttocks, initiated 1/13/14."</li> </ul> <p>The resident's Physician's Orders documented, in part:</p> <ul style="list-style-type: none"> <li>-On 11/17/13, "Calmoseptine to buttocks after</li> </ul>	F 314			

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(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 314	<p>Continued From page 49</p> <p>each incont [incontinent] episode. DX [diagnosis]: open area to (r) [right] buttocks;</p> <p>-On 1/12/14, Turn Q2 HRS [every 2 hours] and prn [as needed], float heels while in bed, avoid supine position; Wound clinic referral, Air bed per protocol;</p> <p>-On 1/21/14, Cleanse coccyx area w/ wc [sic]. Pat dry w/ gauze. Apply silvasorb gel to open areas, apply skin prep around wound, cover with mepon [sic] of dressing, change daily. Roho cushion to w/c [wheel chair];</p> <p>-On 1/17/14, Prevalon Boots to BLE while in bed; and</p> <p>-On 2/4/14, Continue [with] santyl dsg [dressing] [change] to sup [sic] and inf [sic] buttocks q [every] day. Turn pt Q 2 [hours] while in bed. Avoid sitting for prolong times [sic]."</p> <p>Note: a Roho cushion is a brand of pressure relieving cushion that fits in a wheelchair. Prevalon boots are a brand of boot that is designed to lift the foot off the mattress reducing pressure on the heel.</p> <p>On 2/10/14, the resident was observed to be lying flat in bed, positioned on her left side under her covers. She was wearing a sweater with the pull alarm attached to her pillow and her sweater. The resident was wearing non-skid socks and her heels were not floated. She was lying on a pressure reducing mattress. She was observed in this same position at the following times: 11:00 AM, 1:35 PM, 2:30 PM, 3:00 PM, and 4:10 PM.</p> <p>On 2/10/14 at 3:00 PM and 4:10 PM, the resident was observed to be awake and non communicative while in her bed.</p> <p>On 2/11/14, the resident was observed in her wheelchair with a Roho cushion at: 8:10 AM, 8:20</p>	F 314			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 314	<p>Continued From page 50</p> <p>AM, 9:45 AM, 10:40 AM, 12:10 PM, 12:35 PM, 12:37 PM, and 1:05 PM.</p> <p>On 2/11/14 at 2:20 PM, the resident was observed to be in bed positioned on her left side under multiple blankets. Her heels were not floated and were in contact with the mattress.</p> <p>NOTE: During the period of 2/10-2/12/14, the resident was not observed wearing Prevalon boots and did not have her heels floated while she was in bed. She remained in bed 2/10/14 for the entire day, despite being wakeful in the afternoon, and was not observed to be repositioned. Additionally, the resident was observed to spend several hours up in her wheelchair on 2/11/13 from 8:10 AM through 1:05 PM. There was no foot cradle or Keen Wedge observed in her bed from 2/10/14-2/13/14.</p> <p>On 2/12/14 at 3:20 PM, the DON and DDCO were questioned regarding the resident's care. The DDCO said, "We'll look into it and see." When asked why the pressure ulcer on her buttocks was unstageable, the DON said, "When there is any slough on it anywhere, it is unstageable."</p> <p>On 2/13/14 at approximately 3:30 PM, the DON and DDCO were re-interviewed regarding the resident's care. When asked what the facility had done to prevent the resident's pressure ulcers, the DON stated the following timeline: "On 9/6/13 a pressure reducing mattress and gel cushion for the wheelchair were implemented, on 11/17/13 the calmoseptine for incontinence after incontinent care to the peri region was implemented, on 12/9/13 we tried bowel movement scheduled for incontinence, on</p>	F 314			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 314	<p>Continued From page 51.</p> <p>12/20/13 she started wearing pullup briefs. She was repositioned before 1/10/14 but not on a schedule; it was not documented. Her Braden on 12/1/13 was 17 so she was at low risk." The DON and DDCO stated they believed a primary reason for her pressure ulcer development was related to moisture, not immobility. The DON said, "She has Parkinson's and [Resident's Physician] feels that her disease is progressing and so she will continue to get worse." The DDCO said, "It is getting better more quickly with antifungals and incontinence products." When asked if they had looked into additional incontinence products as they suspected the ulcer was a result of moisture skin damage, the DDCO said, "We could look into it; we have all kinds of products here." When asked about the resident's Care Plan to wear Prevalon boots, the DON said, "The boots were discontinued." The DDCO said, "The care plan wasn't updated for the Keen Wedge or Prevalon Boots." The DON and DDCO were informed of the surveyor's multiple observations of the resident remaining in bed on her left side for much of 2/10/14; they stated they would look into that issue.</p> <p>On 2/12/14 at 5:30 PM, the Executive Director, DON, DDCO, and DDCO corporate supervisor were notified of the concern.</p> <p>Resident #1 was admitted to the facility on 2/22/12 with multiple diagnoses which included falls, stroke, and malnutrition.</p> <p>2. Resident #1's Quarterly MDS assessment dated 12/6/13, documented the resident: -Had a BIMS of 12, indicating the resident was cognitively intact; and -Required extensive assistance of one person for</p>	F 314		

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 314	<p>Continued From page 52 bed mobility and transfer.</p> <p>The resident's Care Plan included a focus area documented on 1/4/14, "[Resident] has an actual skin impairment to her left toes, left flank area, [related to] scapula, and lower to left [sic] spine to mid spine related to burns." Goals documented: "[Resident] will heal without signs or symptoms of infection by next [sic] review date." Interventions documented: "-Pravalon boot on left foot at all times."</p> <p>On 2/10/14 at 2/11/14 and 2/12/14, The resident was observed to be in bed multiple times with no Pravalon boot in place.</p> <p>On 2/13/2014 at 3:30 PM the DON and DDCO were interviewed regarding the resident's care. When asked why the resident was not observed wearing the Pravalon boot as the care plan indicated the DON said, "It should be there; it wasn't? It was on on Saturday. It was not on yesterday when we checked so we put it back on." When questioned how the facility ensures that the resident's receive interventions care planned the DON said, "The Kardex with each ADL [activity of daily living], The CNA's have access to it. These boots are washable. We think that it got sent for laundry and not returned."</p> <p>3. Facility policy for the Application of Removable, Performed Splints, dated 10/31/06 documented: -"Splinting is used primarily to immobilize broken bones...in nonemergency situations, a nurse would assess the extremity and apply the splint according to a physician's order." -"Verify the order for: a. For proper application, if other than manufacturer's instructions.</p>	F 314		

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 314	<p>Continued From page 53</p> <p>b. Schedule of application..."</p> <p>-"During the time frame that the resident is wearing the splint, observe the area distal to the splint for:</p> <p>a. Complaints of pain and/or signs [and] symptoms of non-verbal pain</p> <p>b. Rubbing</p> <p>c. Pressure</p> <p>d. Changes in skin condition</p> <p>1) Color-Redness, cyanosis...ecchymosis</p> <p>2) Swelling/edema</p> <p>3) Rash/excoriation...</p> <p>4) Odor...</p> <p>g. Proper alignment and positioning of the splint..."</p> <p>Resident #4 was admitted to the facility on 4/25/08 with multiple diagnoses which included hydrocephalus with the placement of a VP shunt, right-sided CVA with left hemiparesis, diet controlled DM, osteoarthritis, and chronic pain.</p> <p>On 12/25/13, an "Addendum: Final X-Ray Report" in Resident #4's medical record documented Exam Type as, "Portable Shoulder Left." Findings documented, in part, "Acute Proximal humeral fracture noted." The addendum documented, "There is minimal osteoporosis."</p> <p>On 12/25/13 at 12:37 PM, a physician's order documented, "Place Pt in a sling and swath, no lifting or movement with the shoulder."</p> <p>NOTE: Please see F309 as it pertains to pain and delay of treatment and F323 as it pertains to fractures.</p> <p>Resident #4's Nursing Progress Notes documented:</p>	F 314		

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 314	<p>Continued From page 54</p> <p>-12/28/13 at 5:22 PM. "small dime-sized, unopened blister on center chest from left arm brace resting on chest..."</p> <p>-12/29/13 at 9:08 PM. "Pt has blister on chest still intact...readjusted sheet that is placed over blister..."</p> <p>-12/30/13 at 6:24 PM. "Blister swabbed with Betadine as ordered. Also sling padded. Skin checked under sling with no skin issues noted. No [signs and symptoms] of infection at blister site..."</p> <p>-12/31/13 at 10:18 AM. "IDT review of event on 12/28/13...Resident found with blister to upper left chest from seam of sling. Resident has a history of fragile skin, pressure ulcers, and diabetes..."</p> <p>-12/31/13 at 4:37 PM. "New orders [received] for blister [treatment] including loose fitting tubigrip for LUE and tank top on at all times. Remove for bathing."</p> <p>Resident #4's most recent Significant Change of Condition MDS, dated 1/16/14, coded: -Unable to complete BIMS, assessed by staff with severely impaired cognition; -Non-verbal, able to understand simple, basic, direct information; -Dependent on 2 persons for transfers and dressing; and -At high risk for the development of pressure ulcers, with no pressure ulcers present.</p> <p>Resident # 4's MAR for December 2013 documented, "Sling [and] Swath 24/7", beginning 12/25/13.</p> <p>NOTE: It was not clear from this entry where the sling and swath were to be applied. There were no instructions as to how the sling was to be positioned, nor instructions to check the skin near or under the sling and swath. It was not clear</p>	F 314			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 314	<p>Continued From page 55</p> <p>from this entry on the MAR how this was to be; however, between 12/25/13 and 12/31/13 there were only three sets of initials - once on 12/27/13 and twice on 12/29/13.</p> <p>Resident #4's TAR for December 2013 documented:</p> <ul style="list-style-type: none"> <li>-"[L] arm sling on at all times, monitor strap sites [every] shift." Start date documented as 12/25/13.</li> <li>-"Circulation [check] to L arm [and] hand [every] shift." Start date documented as 12/25/13.</li> <li>-"Check skin under sling [every] shift [and] prn." Start date documented as 12/30/13. NOTE: This treatment was started 2 days after the resident was noted with a blister on his chest from the sling.</li> </ul> <p>Resident #4's Braden Pressure Sore Risk Category was identified on 10/20/13 as Moderate Risk. On 1/20/14, the category was identified as High Risk.</p> <p>Resident #4's care plan documented: Focus area of, "...actual impairment to skin integrity diabetic ulcer, abrasions to arm, back r/t end stage disease process, immobility, hx of pressure ulcers, and a recent decline in health." Date initiated 1/20/14, revised on 2/21/14.</p> <ul style="list-style-type: none"> <li>-Goal of, "Diabetic ulcer will not decline through the next review date." Initiated on 1/20/14, revised on 2/6/14. [NOTE: There were no goals identified in terms of the resident's pressure ulcer risk, even in light of his increased Braden risk category, and a stage II pressure ulcer discovered on his chest on 12/28/13.]</li> <li>-Interventions included: <ul style="list-style-type: none"> <li>**"Cleanse skin under L[eft] wrist brace daily and PRN." Date initiated 1/20/14, revised on 1/21/14.</li> <li>**"Pt to have blue "comfy" splint applied to L</li> </ul> </li> </ul>	F 314			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 314	Continued From page 56 wrist/hand with finger separator between fingers and velcroed onto the splint. Place light blue "donut-like" cushion around pt's wrist at his chest to reduce pressure between hand and chest." Date initiated: 4/22/13.  On 2/10/14 at 10:00 AM, the resident was observed lying in his bed, in his room. An air mattress and black Prevalon boots were in place. The resident was wearing a hospital gown, tied behind his neck but otherwise draped over the resident and unsecured down the back. There were geri-sleeves on his arms. His left arm was contracted so as to lay across his chest. His right arm was laying along his right side, with a soft blue trough-shaped sling laying beneath his arm and pillows beneath the sling. There was a blanket draped over a foot cradle at the foot of his bed.  On 2/12/14 between 12:45 and 2:45 PM, the DNS and DDCO were interviewed about Resident #4's skin breakdown. The DNS stated the blister on R #4's chest came from the resident's sling positioning his left hand so as to rest on his chest, and caused the hand to rub against his chest. The DNS stated the physician's order was to leave the sling and swath in place "24/7" [at all times]. When asked what the facility had done to ensure the skin surrounding the sling and swath was checked regularly, the DNS referred to the directions on the resident's TAR for instructions to manage the sling. When questioned, the DNS stated the area where the chest blister developed would have been an area the nursing staff were able to visualize, even with the sling and swath in place undisturbed. The DNS stated once the blister was discovered, the facility padded the area to prevent further recurrence. The DNS was	F 314			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 314	<p>Continued From page 57</p> <p>unable to describe why the area was not padded before the blister developed.</p> <p>On 2/13/14 at 6:30 PM, the Administrator, DNS, and DDCO were informed of the surveyor's concerns. The facility offered no further information.</p> <p>4. Resident #3 was admitted to the facility on 3/5/13 with diagnoses that included rheumatoid arthritis, chronic pain and edema.</p> <p>The resident's Quarterly MDS dated 12/15/13, documented: *BIMS: "13" cognition intact. *Risk of Pressure Ulcers: "Yes"</p> <p>The resident's Braden Scale, dated 12/5/13, documented; *Risk for developing pressure ulcers: "High Risk."</p> <p>The resident's Patient Nursing Evaluation dated 12/5/13 documented: *E. Other Skin Risk Factors 1. Extrinsic risk Factors (check all that apply). 1A. "Requires staff assist to move to relieve pressure over any one site." 1B. "Bed/chair bound." 1C. "Requires special mattress/chair cushion."</p> <p>The resident's Care plan documented (date?): *Focus: "(Resident's name) has actual impairment to skin abrasion to buttocks, blemish to right ear, r/t (related to) fragile skin, Hx. (history) PU (pressure ulcer) stage 2, immobility, bedpan removal." Date initiated: 3/7/13. Revision on: 1/29/14 *Interventions: -"Air mattress to prevent skin breakdown." Date</p>	F 314			

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

PRINTED: 03/03/2014  
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>C</b>  <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 314	<p>Continued From page 58</p> <p>initiated: 2/10/14. -"Float heels at all times while in bed." Date initiated: 3/7/13.</p> <p>*Focus: "(Resident's name) has an open blister to her rt. (right) upper medial gluteal fold." Date initiated: 11/6/13 *Interventions: -"Off load rt. gluteal fold." Date initiated: 11/6/13</p> <p>On 2/10/13 at 1:15 pm, CNA #24 provided cares for the resident. When cares were completed, the CNA positioned a pillow at the side of the resident's left leg, and under the back of the legs. The left heel was directly on the bed. The resident was on her back.</p> <p>On 2/11/14 at 9:22 am, the surveyor observed the resident was on her back in the bed with the head of her bed elevated. There was a pillow behind her legs. The left foot, lateral side, was directly on the bed. The right foot was crossed over the ankle of the left foot. The resident was asked about the positioning of the pillows, and stated, "I have the pillows because of the knee, not the heels." The resident was asked if she ever got out of bed, and she stated, "No, its too hard with the Hoyer [mechanical lift], it makes my joints hurt. They get me up to take me to the shower one time a week." The resident was asked if she always laid on her back, and she replied, "I always lay on my back because I can't lay on my shoulders. Oh, I will flip onto my side, then the other sometimes."</p> <p>On 2/11/14 at 10:50 am, the resident was on her back with the head of her bed elevated. The left foot, lateral side, was directly on the bed, and the right leg was crossed over the left ankle. The</p>	F 314			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 314	<p>Continued From page 59</p> <p>resident was asked if she had been on her back since the 9:22 am observation, she stated, "Yes, but I shift my hips a little bit." There was a pillow positioned beside the right side of the resident, right arm resting on the pillow.</p> <p>On 2/11/14 at 12:05 pm, the resident's position was unchanged.</p> <p>On 2/11/14 at 2:05 pm, the surveyor observed the resident was on her back, the head of her bed was elevated. The resident's left foot, lateral side, was directly on the pillow that was under the lower legs, with the right foot crossed at the left ankle. Multiple sores were noted to the lateral side of the left foot, and the skin was visibly reddened along the lateral side of the foot. The resident was asked how long the visible sores on the lateral aspect of the foot had been present, she stated, "A couple weeks, they don't know what they are. They have been washing them and taking care of them." When the resident was asked if they were painful, she replied, "Nope, they are not painful at all."</p> <p>On 2/11/14 at 2:55 pm the resident's position was observed unchanged.</p> <p>On 2/12/14 1:40 pm, the resident was observed lying with the lateral side of the left foot directly on the bed. The right foot was crossed over the left foot at the left ankle.</p> <p>On 2/12/14 at 3:45 pm, the resident's lateral side of the left foot was observed directly on the bed. There was a pillow on the left side supporting the left knee. CNA#25 was in the room and had provided cares for the resident. CNA#25 was asked if there were any special cares they were</p>	F 314		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(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 314	<p>Continued From page 60</p> <p>to provide to the resident's heels to prevent skin problems The CNA replied, "We put lotion on them, the nurse would know if there is anything else."</p> <p>On 2/13/14 at 9:15 am, the resident's lateral side of the left foot was observed directly on the pillow which was under the lower legs. The right foot was crossed over the left lower leg. The resident stated, "I just woke up."</p> <p>On 2/13/14 at 10:07 am the DON and DDCO were interviewed about the concerns with the resident. When asked how off loading of the gluteal fold was being provided, the DON stated, "They are supposed to have pillows for positioning." The DON and DDCO were informed of the observations of the left foot not being floated, the reddened lateral left foot and the pillows beside the resident, the DDCO stated, "You obviously have a lot of observations but we will see what we can do."</p> <p>On 2/13/14 at 12:45 pm the surveyor observed the resident's skin with the Facility NP (Nurse Practitioner.) The resident's feet were floated on a "Keen" wedge pillow, no redness was visible, small dark areas were present. The NP stated the left foot, and heel areas were not Stage 2 pressure ulcers. "Not sure what they are, they are like blood blisters. We are sending her to a dermatologist." The NP observed the dark areas to both feet and fingers. The observations, and concerns were explained to the NP. The resident was asked how the new pillow was under her legs, the resident stated, "This feels great. It's very comfortable."</p> <p>On 2/13/14 at 1:20 pm, the surveyor told the DON</p>	F 314	<p><b>Center Systems</b></p> <p>SDC, DNS, and/or DDCO has educated clinical staff regarding prevention and treatment of pressure ulcers to include but not limited to,</p> <ul style="list-style-type: none"> <li>▪ Prevention of recurrent wounds</li> <li>▪ Clarification of orders for non-removable braces</li> <li>▪ Exploration of treatment options based upon root cause of wound</li> <li>▪ Consistent implementation of interventions</li> </ul> <p>Pressure ulcer treatment and prevention plan implementation is reviewed through ID Team and clinical rounds, as well as with clinical management review of weekly skin check, weekly documentation of wound healing, and treatment administration record.</p> <p><b>Monitor</b></p> <p>DNS and/or designee will review non-removable brace orders, and audit weekly skin checks for implementation and updates to skin prevention program. Four residents will be reviewed weekly for 4 weeks, then 2 residents weekly for 4 weeks. Clinical rounds will be made 3 times weekly for 8 weeks to validate consistent implementation of interventions. Starting the week of March 17, 2014, documentation will take place on the PI Audit Tool. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p> <p><b>Date of Compliance</b> March 21, 2014</p>		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(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 314	Continued From page 61 that the resident's feet were observed with the NP, and the feet looked much better. The DON stated, "Oh, good I am glad."  On 2/13/14 at 6:15 pm, the Administrator, DON and DDCO were informed of the finding. No additional information was provided.	F 314			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, 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 record review and staff interview, it was determined the facility failed to ensure 1 of 9 (#11) sampled residents reviewed for incontinence care, received adequate incontinence care. This had the potential to harm the resident if they developed UTI's or experienced skin breakdown. Findings included:  1. Resident #11 was admitted to the facility on 8/20/13 with multiple diagnoses including aftercare following surgery for neoplasm and unspecified disorder of bladder.  The resident's 5 day MDS assessment dated	F 315	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.  <b>F315 Resident Specific</b> Resident # 11 discharged prior to survey.  <b>Other Residents</b> Clinical Management team reviewed residents with catheters for documentation that catheter care was provided. No adjustments were indicated.  <b>Center Systems</b> SDC and/or DNS have re-educated the licensed nurse staff regarding consistent and timely documentation of catheter care for current residents and new admissions.		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605	
(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 315	Continued From page 62 8/25/13, documented the resident required two person extensive assistance for transfers, one person extensive assistance for toilet use, and had an indwelling catheter.  A Physicians Order dated 8/22/13, documented, "Foley catheter care Q [every] shift."  The resident's August 2013 MAR documented catheter care was completed on 3 of 3 shifts for the dates 8/21 through 8/23/13; however there were blank spaces for the AM and PM shift on 8/24/13.  On 2/13/14 at 4:40 PM the DON and DDCO were interviewed regarding the catheter care. When asked if the catheter care was done, the DDCO stated, "It looks like it wasn't documented."  On 2/13/14 at 6:05 PM the Administrator, DON, DDCO, and Divisional Vice-President were informed of the catheter care issues. No further information was provided by the facility.	F 315	<b>Monitor</b> The DNS and/or designee will review treatment administration records for consistent documentation of catheter care. Two residents will be reviewed weekly for 8 weeks. Starting the week of March 17, 2014, documentation will take place on the PI Audit Tool. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.  <b>Date of Compliance</b> March 21, 2014	
F 317 SS=D	483.25(e)(1) NO REDUCTION IN ROM UNLESS UNAVOIDABLE  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff	F 317	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605	
(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 317	<p>Continued From page 63</p> <p>interview it was determined that 1 of 15 (#3) sampled residents did not receive RNA (Restorative Nurse Aide) services to prevent the reduction in ROM (range of motion). The deficient practice had the potential for more than minimal harm when Resident #3, a bed-bound resident, had not been provided a RNA program as recommended by the facility's Physical Therapist. Findings included:</p> <p>Resident #3 was admitted to the facility on 3/5/13 with diagnoses that included, rheumatoid arthritis, chronic pain and edema.</p> <p>The resident's Quarterly MDS (Minimum Data Set) dated 12/15/13, documented: *BIMS (brief interview of mental status) score: "13" cognition intact. *Functional limitation in ROM: -A. Upper extremity- "both sides." -B. Lower extremity- "both sides." *Special Treatments, Procedures, and Programs: -A. Range of Motion (passive)- "0" -B. Range of motion (active) "0"</p> <p>The resident's Physician Orders for 2/1/14 through 2/28/14 documented: *Therapy evaluation and treatment: Occupational. Start date: 3/5/13.</p> <p>The resident's Occupational Therapy Evaluation dated 3/6/13, documented: *Justification for Skilled Services: "Eval(uation) only - recommend RNA program." *Summary statement: "This is a well-known (age) female. Her baseline is staying in bed most of the day and has total (assist) (with) all cares. She wishes to stay [in] a Hoyer lift for txfers. (transfers)."</p>	F 317	<p><b>F317 Resident Specific</b> Clinical staff re-evaluated resident # 3 for a Range of Motion (ROM) program. Care plan is adjusted as indicated.</p> <p><b>Other Residents</b> Clinical Management team reviewed residents that are current residents but have discharged from physical therapy (PT) and/or occupational therapy (OT) for restorative nursing referral. Care plans were adjusted and ROM provided as indicated.</p> <p><b>Center Systems</b> SDC and/or DNS have re-educated licensed nursing staff regarding the process for therapy referrals to the restorative nursing programs. If residents refuse ROM programs, documentation is provided and alternate plans trialed. Clinical Management team will review residents with orders with discontinuation of therapy for potential restorative nursing ROM program.</p> <p><b>Monitor</b> The DNS and/or designee will review discontinuation of therapy orders on current residents for potential restorative nursing referral. Two residents will be reviewed weekly for 4 weeks, then 1 resident weekly for 4 weeks. Starting the week of March 17, 2014, documentation will take place on the PI Audit Tool. Any concerns will be addressed immediately and discussed with the PI committee as indicated. 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: 03/03/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605	
(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 317	Continued From page 64  The resident's Physical Therapy Evaluation dated 3/7/13, documented: *Justification for skilled services: "Pt. (patient) (refused) skilled PT services- "Does not think it will do any good." *Summary Statement- "Pt. (refused) therapy services (and) thinks that any activity would just increase pain (and) will not improve function."  The resident's Care Plan documented: *Focus: "(Resident's name) has risk for developing an impairment in functional joint mobility related to weakness, discomfort when moving, poor motivation, inactivity resulting from a medical condition, not able to achieve full functional ROM, decreased ability to self perform ADLs(activity of daily living) independent." Date Initiated: 3/7/13 *Goals:"(Resident's name) will remain free from complications of impaired range of motion." Date Initiated: 3/7/13. Target date: 12/22/13. Revision on: 1/13/14 *Interventions: -"Pre-medication for comfort as indicated prior to passive range of motion." Date initiated 3/7/13. Position responsible: RN, LPN -"Refer to therapy as necessary" Date initiated: 3/7/13 Position responsible: RNA -"Report and document any declines in ability." Date initiated: 3/7/13 Position responsible: RNA  On 2/10/13 at 1:15 pm, CNA #24 was observed to provide cares for the resident, ROM was not provided.  On 2/12/14 at 1:35 pm, CNA #3 and LN #6 were observed to provide cares for the resident, ROM was not provided.	F 317	<b>Date of Compliance</b> March 21, 2014	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605	
(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 317	Continued From page 65  On 2/13/14 at 10:07 am, the DON and DDCO were interviewed concerning the OT recommendation for the resident to be on the RNA program. They were asked, if the resident was receiving ROM, who performed ROM with the resident and documentation of it. The DON stated, "Yes, if they are doing it we should have documentation on it. We do keep a record of it." [NOTE: On 2/13/14 the DDCO verified the facility did not have documentation of the resident's RNA program to prevent declines in ROM.]  On 2/13/14 at 6:05 pm, the DDCO stated, "We do not have any ROM notes on (Resident's name.)"  On 2/13/14 at 6:15 pm, the Administrator, DON, and DDCO were informed of the findings. No additional information was provided.	F 317		
F 323 SS=G	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, record review, family, resident and staff interviews, it was determined that the facility failed to provide adequate supervision to prevent falls with injuries, fractures, and burns for 3 of 15 (#s 1, 8, and 4) sampled	F 323	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014	
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 66</p> <p>residents.</p> <p>*Resident #1 was harmed when the facility failed to implement interventions to reduce hazards and risks when the resident with a history of falls, fell on a heater which was near her bed and was harmed when she sustained multiple second and third degree burns.</p> <p>*Resident #8 was harmed when the resident slid off the bed onto the floor, resulting in a fracture to the right lower leg.</p> <p>*Resident #4, who was dependent for the provision of care, was harmed when he sustained a fracture to the upper left arm. Also, the facility failed to initiate a timely and thorough investigation when staff noted a sudden increase of passive range of motion on an extremity which had been non-moveable for a number of years. Additionally, the facility failed to ensure the environment remain free from accident hazards when side rails were implemented without being evaluated for safety for 3 of 3 sampled residents (#s 1, 4, and 5). This had the potential to harm the residents due to the risk of limb entrapment in the side rails.</p> <p>1. Resident #1 was admitted to the facility on 2/22/12 with multiple diagnoses which included falls, stroke, COPD (Chronic Obstructive Pulmonary Disease) and malnutrition.</p> <p>a. Resident #1's Quarterly MDS assessment dated 12/6/13, documented the resident:</p> <ul style="list-style-type: none"> <li>-Had a BIMS of 12, indicating the resident was cognitively intact;</li> <li>-Required extensive assistance of one person for bed mobility and transfer;</li> <li>-Was frequently incontinent of urine; and</li> <li>-Had a fall since admission with no injury.</li> </ul>	F 323	<p>F323</p> <p><b>Resident Specific</b></p> <p>Resident # 1, 4, and 8 were self reported to the Bureau of Facility Standards prior to survey. Care plans are updated as indicated. Resident # 1, 4, and 5 had their rails discontinued.</p> <p><b>Other Residents</b></p> <p>Clinical Management team reviewed residents with accidents, injuries, ongoing pain, and airbeds over last 30 days for adequate supervision to prevent falls. Care plans were updated as indicated. Residents with side rails were reviewed for medical necessity and safety. Rails were assessed with care plan updates or discontinued as indicated.</p>	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST	STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 67</p> <p>The resident's Care Plan included the focus area documented on 6/17/13, "[Resident] had an actual fall with No injury r/t [related to] Unsteady gait, Poor Balance, recent CVA." Goals dated 9/19/13, documented: "[Resident] will resume usual activities without further incident through the review date."</p> <p>Interventions dated 6/17/13, documented: -Continue skilled therapies for strengthening; -Encourage to use call light for assistance; -Monitor/document/report PRN [as needed] x 72h [every 72 hours] to MD [Medical Doctor] for s/sx [signs and symptoms]: Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation; and -Neuro-checks per policy and procedure."</p> <p>The resident's Care Plan included the Focus area dated 11/25/12, documented "[Resident] has potential impairment to skin integrity r/t [related to] fragile skin/hx. [sic] of coccyx impairment." Goals dated 11/25/12, documented: "Staff will have interventions in place to prevent altered skin integrity. Resident will not develop any new areas of skin breakdown through next review date." Revision dated 6/11/13.</p> <p>An intervention dated 11/25/12-"[Resident] needs air mattress to protect the skin while in bed."</p> <p>The Resident's Incident Investigation Directives Post Fall documented on 11/20/13: *2:20 AM, "Call light was on, CNA entered room [and] found resident on floor beside bed. [sic] Was laying on LT [left] side, with legs under bed. Resident states she rolled out of bed. Denies trying to get out of bed. Interventions included: -Change air mattress [sic] w/th [sic] bolsters; -Neuro [72 hours crossed out]; and</p>	F 323	<p><b>Center Systems</b> SDC, DNS, and/or DDCO have educated and skills checked nursing staff regarding adequate supervision to prevent falls to include but not limited to,</p> <ul style="list-style-type: none"> <li>▪ Timely, thorough investigation and documentation to rule out abuse and identify root cause.</li> <li>▪ Consistent documentation of pain and ROM post fall.</li> <li>▪ Care plan intervention changes to address root cause.</li> <li>▪ Transfer technique for in and out of air beds.</li> <li>▪ Documentation of items that residents need and have been requested from the family.</li> <li>▪ Side rail assessment and safety review.</li> </ul> <p>Prevention of falls is reviewed through shift-to-shift report, daily clinical management meeting, event investigation, and clinical rounds.</p>	
-------	---	-------	---	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 68</p> <p>-Monitor [sic] pain 72 [hours]"</p> <p>Note: Bolsters were not added to the resident's Care Plan even though the above document stated it would be included as an intervention.</p> <p>The resident's interdisciplinary progress notes documented:</p> <p>*1/4/14 at 3:44 AM: "At 0205 [2:05 AM], resident found on the floor between bed and window wall. Skin on back is reddened but blanchable. No apparent other injuries from fall. When moving resident she did touch her upper left arm on the heater. No red spot noted at this time but will continue to monitor that area for possible burn. ROM [range of motion] within normal limits for resident. Neuro checks within normal limits for resident. BP [blood pressure] elevated but is gradually coming back down. Will continue neuro checks and monitoring per protocol x72hrs [hours]."</p> <p>*1/4/14 at 3:50 AM, "When resident returned to bed with assist, complained of pain in left foot. Aide[sic] removed sock to check foot. Found denuded spots on great toe and second toe. Areas white, dry except around edge where skin pulled off by sock. Toes reddened, irritated. Great toe nail black. Areas cleaned, covered with telfa and bactroban, held in place with gauze for protection for the rest of the night. Will request proper tx [treatment] orders."</p> <p>*1/6/14 at 11:09 AM, "IDT review of event on 1/4/14 at 0205. Resident was seen asleep in bed at 0150 [1:50 AM]. At approximately 0205, CNA smelled something burning and found resident with pillow and blanket behind her laying against base board heater. First Aide [sic] initiated. Resident received several burns to left toes and</p>	F 323	<p><b>Monitor</b></p> <p>The ED and/or designee will review events weekly for timely and thorough investigation, validating documentation, and making rounds for intervention implementation. Four residents will be reviewed weekly for 4 weeks, then 2 residents weekly for 4 weeks. Starting the week of March 17, 2014, documentation will take place on the PI Audit Tool. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p> <p><b>Date of Compliance</b> March 21, 2014</p>	

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 323	<p>Continued From page 69</p> <p>back. She has a swollen left ankle. X-ray was negative for fracture. See assessments dated 01/05/14. Resident's pain is controlled with Norco. Treatment initiated with blister to rt [right] scapula resolved. Family and MD notified. Bed was moved away from heater. All beds against base board heaters were turned away and contractor will move all base board heaters to the center walls away from the beds. Will monitor and treat until resolved."</p> <p>A undated Facility Incident Investigation Directives Post Fall documented the following: "Summary of Event: CNA heard someone calling for help. Search rooms and found [resident] had rolled off the back side of her bed onto the baseboard heater. LN [licensed nurse] assessment identified open areas, first aid [sec] provided and MD notified for orders.... Immediate Interventions: -Bed turned away from heater and window to provide distance. -Wound treatment initiated. -Pravalon Boot to left foot and keen wedge to float both heels. -1/4 rails bilaterally to assist with bed mobility. -Foot cradle to elevate bedding. -Monitoring for increase pain and medicate as ordered. -Continue with air mattress and off load areas affected. -Neuro's initiated Investigation and Conclusion: Upon completion of a thorough investigation including resident interviews, observation, and record reviews it is determined that [the resident] moves around in her bed. At approximately 0130 she was provided cares and repositioned in the</p>	F 323		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 70 middle of her bed with her call light. Around 0150 the LPN [Licensed Practical Nurse] observed [the resident] curled in a fetal position on her bed with her call light. [Resident] states she rolled out of her bed by the window and became stuck between the bed and the wall heater. She states that it was hot and she called for help. One CNA reports that she heard someone call for help, but then did not hear anything more. She went to the nurse's station to see if anyone else had heard anything. Simultaneously, another CNA was at the time clock checking out for lunch at 0205 when he smelled something burning. The two CNA's heard [the resident] call out and found her lying on the floor on her right side with a blanket and pillow between her and the baseboard heater. They moved the bed away from [resident] and called for the LN. The blanket and pillow had scorched marks. The resident gown and socks did not have any evidence of burning. The LN assessed [the resident] with the following: -left great toe nail appeared busied with the top missing and white like dry patch [sic] -2nd toe had denuded area -left lower back with reddened blanchable area -no blisters noted at this time MD was notified and wounds treated as indicated At approximately 0600, two LN's completed an additional skin check with burns advancing as following [sic]: -left great toe and left 2nd toe open areas -blisters to left 3rd and 4th toes -blister to left rear iliac crest and right scapula -open blister to left lower mid back and mid spine area. MD was updated and orders received. [The resident] complained of left ankle pain. X-ray ordered and results were negative.	F 323			

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

PRINTED: 03/03/2014  
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>C</b>  <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 323	<p>Continued From page 71</p> <p>In Conclusion, it is determined that [the resident] received a variety of burns after she rolled out of bed and onto the baseboard heater. Plans to Prevent Reoccurrence: -All beds next to base board heaters were turned to provide more distance. -Contractor is moving all base board heaters from under the window and way from the resident beds." Note: The resident's Facility Incident Investigation Directives Post Fall form did not document bolsters were on the bed at the time of the 1/4/14 fall. The bolsters were to be added as an intervention following a fall from bed on 11/20/13, but was not found on the resident's care plan.</p> <p>Refer to F309 for information related to a delay in treatment.</p> <p>On 2/12/14 at 3:30 PM the DON and DDCO were interviewed regarding the space between the bed and heater. The DON said, "The bed wasn't that close to the heater. The night stand could have fit between the bed and the heater." The DDCO said, "We moved the furniture then, because the fall and burn happened. It was the blanket and pillow that got scorched."</p> <p>b. Resident #1 was observed multiple times from 1/10 thru 1/13/14 in a bed with a left side rail up.</p> <p>On 2/10/14 at 11:05 AM, The resident was observed to be lying sideways on the mattress with her head resting against the left side rail. The call light attached to a pillow near residents neck with her pillows near resident arms. The head of the bed was elevated at approximately 80 degrees. When the resident asked about comfort levels she said, "I'm not comfortable because my</p>	F 323			

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 72</p> <p>head is on something right there." When the resident was asked how she happened to be positioned this way she replied, "I don't know." The resident stated she would like to be repositioned in bed. The surveyors notified staff and four staff members including the DON came into room, repositioned resident and provided cares.</p> <p>On 2/10/14 at 11:20 AM, CNA #18 was asked when the last time the resident was turned or observed and she said, "She turns herself, she is all over that bed."</p> <p>On 2/13/14 at 3:30 PM, the DON and DDCO were interviewed and asked for side rail safety assessment documentation for the resident. A "Bed Safety Evaluation" document was provided which was signed and dated on 1/4/14. When asked if there was another form which addressed safety of bed rails specifically, the DDCO stated the form provided was the only form used. The DDCO said, "The form we use is to assess for mobility but not for safety. That has not been documented. She has foam bolsters as part of her mattress. They are attached under the cover so they can not be easily or mistakenly removed."</p> <p>2. Resident #8 was admitted to the facility on 2/19/06 with diagnoses that included senile dementia, osteoarthritis and depressive disorder.</p> <p>The resident's Annual Minimum Data Set (MDS), dated 7/3/13, documented: *BIMS: 3- severely impaired cognition; *Bed mobility: 3-2 extensive assistance, one person; and *Transfer: 3-2 extensive assistance, one person.</p>	F 323			

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

PRINTED: 03/03/2014  
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>C</b>  <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 323	<p>Continued From page 73</p> <p>The resident's Quarterly MDS, dated 11/14/13, documented: *BIMS: 1- severely impaired cognition; *Bed mobility: 4-2 total dependence, one person; and *Transfer: 3-3 extensive assistance, two person. NOTE: The resident had a decline in Bed mobility and Transfer, from the Annual MDS and the Quarterly MDS.</p> <p>The resident's Care Plan documented: *Focus: "(Resident's name) has an ADL(activity of daily living) self care performance deficit r/t (related to) disease process deterioration in ADL's, declining ability to make decisions." Date initiated: 2/19/13 *Interventions: -Bed mobility: "(Resident's name) requires 2 staff participation to reposition and turn in bed." Date initiated: 2/19/13. -Transfer: "(Resident's name) requires 2 pr (person) sera-lift [mechanical device used to transfer residents] for transfers." Date initiated: 2/19/13.</p> <p>The resident's Post-Fall Investigation, event date 9/6/13 at 4:00 pm, documented: *Fall location: "Next to transfer surface." *Verbal Fall description: "aide assisting resident up from bed into w/c (wheelchair) - sat resident up on side of bed to hook up sit to stand [mechanical device used to transfer residents]- resident started to slide off side of bed so aide lowered resident to the floor." *Resident and equipment (check all that apply): "slipped." *Signature Licensed Nurse Completing Investigation: Was left blank. *Date of completion: Was left blank.</p>	F 323			

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 74  The CNA written statement, dated 9/8/13, documented: "I was hooking up (Resident's name) up (sic) to the sit-to-stand while she was sitting on her bed. She started to slide off of her bed before I could finish getting her hooked up. I tried to hold her up while her room mate, (Resident's name), put her call light on & (Resident's roommate) tried to open the door to her room but couldn't turn the handle. I ended up sitting (resident's name) on the floor. When I did that, I noticed that her feet were on the sit to stand, kind of wrapped around the base of it. She did not complain of pain in her ankle or foot at that time. This happened on 9-6-13."  The resident's IDT (Interdisciplinary) progress notes documented: -9/6/14 7:24 pm: "At 1600 (4:00 pm), when assisting resident to get up from bed to w/c for dinner, resident started sliding off side of air bed. Aide lowered resident to floor to prevent fall, then called for assist. Resident assisted up to w/c with 3 assist. Resident noted to have a 1.5 cm diameter skin tear to right forearm where she bumped her arm against bottom of sit-to stand. ST (skin tear) cleaned, flap reappointed, steri-strips applied. Will monitor for s/s (signs and symptoms) infection until healed." -9/7/13 2:27 am: "Resident resting in bed at this time. No apparent problems from fall. No complaints of pain." -9/7/13 5:29 pm: "Resident alert. Up in w/c for evening meal. No apparent problems from fall." -9/8/13 10:30 am: "At appx. (approximately) 0800 (8:00 AM) staff notified nurse resident had a swollen and bruised R (right) ankle, nurse notified supervisor, MD notified. Order for X-ray received. At appx 1030 (10:30 AM) xray taken, awaiting	F 323			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 323	<p>Continued From page 75 results."</p> <p>-9/8/13 1:04 pm: "Final Xray report received, results as follows. IMPRESSION: Mild DJD (degenerative joint disease). Acute distal fibula (lateral malleolar) fracture. Medial malleolar hairline fracture VS (versus) pseudo-finding. Follow up Xray suggested for further assessment."</p> <p>-9/8/13 3:33 pm: "Dr. (name) notified of X-ray results. Order rec'd and noted for PT (physical therapy) to eval(uate) for a splint or boot, NWB (nonweight bearing) for 6 weeks. Make appt (appointment) with ortho, Elevate extremity and apply ice to affected area PRN (as needed.)"</p> <p>-9/9/13 9:34 am "IDT review of event on 9-6-13 at 1600. Resident slid out of bed onto floor when CNA was assisting her in the sit to stand for a transfer. Resident was sitting on her air mattress and slid off. Resident developed a bruise to her rt. ankle which became painful and warm. Xray showed a fracture to the lateral fibula. Ice applied, ortho to see resident., Hoyer transfers, non-wt bearing for 6 weeks, bed rest until eval(uated). Staff education on new care plan restrictions. Monitor for increase pain. MD and family notified. Will assess air mattress setting."</p> <p>-9/11/13 2:26 pm: "Resident had MD visit and returned with a cast on RLE (right lower extremity.) resident does not appear to be in discomfort with cast in place."</p> <p>The resident's Physical Therapy Evaluation dated 10/28/13, documented: *Physical therapy treatment diagnosis: "Diff(iculty) walking." *Additional Medical diagnosis impacting physical therapy: Classification:"s/p (secondary problem) ankle fx. (fracture)." *Prior level of function: "Pt. (patient) was min A</p>	F 323			

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(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)	(X6) COMPLETION DATE	
F 323	<p>Continued From page 76</p> <p>(minimal assist) for bed mob(ility), transfers, &amp; gait (with) FWW (front wheel walker) x 20 (feet) CGA(contact guard assist) w/c mob(ility) short distances in the facility."</p> <p>*Reason for Referral: "Pt. fell &amp; fx. (right) ankle on 9/8/13 &amp; was NWB until 10/24/13, cast removed. MD order for activity as tolerated."</p> <p>*Evaluations Functional Outcome Scores: -Bed mobility: Prior level: "4.0" min -occasional assist (25% or less time or effort to complete); Evaluation score: "1.7" NTD (near total dependence). -Transfers: Prior level: "4.0" min; Evaluation score: "1.7" NTD. -Gait: Prior level: "4.0" min; Evaluation score: "1.0" CD (complete dependence). -Distance: Prior level: "20(feet)"; Evaluation score: "0 (feet)". -Wheelchair Mobility: Prior level: "4.5" CGA; Evaluation score: "1.0" CD.</p> <p>The resident's Physical Therapy Discharge summary dated 11/19/13, documented: -Summary statement: "Pt. has made small gains (with) bed mob(ility) &amp; sit (to)stand/transfer ability but progress has plateaued so pt. will be set up on RNA (Restorative Nurse Aide) program for maintenance." -Discharge summary: - Bed mobility: "2.5-3.0" moderate to maximum assist. -Transfers: "1.7 (with) sara lift (with staff)" -Gait (parallel) bars: "stand 2.0 x 10 seconds." maximum constant assist. W/C mobility: "1.7" NTD.</p> <p>NOTE: The resident required Physical therapy for decline in ADL's after the resident received a right ankle fracture on 9/6/13. Physical therapy scores</p>	F 323			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 323	<p>Continued From page 77</p> <p>documented decline in functional abilities when bed mobility, transfers, gait, and w/c mobility were compared to prior level and discharge level after treatment of the resident.</p> <p>On 2/12/14 at 1:15 pm CNA #5 was observed providing care for the resident. When the surveyor asked the CNA about transferring the resident, the CNA stated, "she used to be just a two person assist for transfers." The surveyor then asked if the resident's transfer assistance had changed since she had a fracture in September. The CNA stated, "Yeah, I think since then she has been a sara (lift transfer)." The CNA was asked about the air mattress; specifically if the LN or CNA's were responsible for turning the mattress on or off, or if they stay on all the time. The CNA stated, "They stay on all the time." The CNA was asked if the staff turned them off when getting residents in and out of bed. The CNA stated, "They stay on, I have one resident (Resident's name) that I turn it off, but the others, they stay on."</p> <p>On 2/13/14 at 10:07 a.m., the DON and DDCO were interviewed concerning the resident's fall on 9/6/13. They were asked if they could explain why the CNA was transferring the resident by herself, whether or not there concerns with the bed, specifically whether it was supposed to be on or off during a transfer, and what was the outcome of the IDT note written on 9/9 pertaining to the assessment of checking the air mattress setting. The DON stated she was "unsure" and would look into it. No further information was provided.</p> <p>On 2/13/14 at 6:15 pm the Administrator, DON, and DDCO were informed of the findings.</p>	F 323			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 323	<p>Continued From page 78</p> <p>On 2/14/14 at 12:00 pm, at the Exit conference, the DCHO provided documentation of the resident's RNA program. No further information was provided on the use of the bed, or why 1 CNA was performing the transfer when the care planned intervention documented a 2 person transfer.</p> <p>3. Resident #4 was admitted to the facility on 4/25/08 with multiple diagnoses which included hydrocephalus with the placement of a VP shunt, right-sided CVA with left hemiparesis, diet controlled DM, osteoarthritis, and chronic pain.</p> <p>Resident #4's Significant Change of Condition (SCOC) MDS assessment, dated, 10/16/13, coded:                      -Unable to complete BIMS, assessed by staff with severely impaired cognition;                      -Non-verbal, able to understand simple, basic, direct information;                      -Dependent on 2 persons for transfers and dressing;                      -Did not ambulate;                      -Pain present, treated with routine pain medication. No PRN medications needed. No non-medication pain relief measures used.                      -Resident unable to rate pain per pain scale, but was not noted with non-verbal signs of pain.</p> <p>Resident #4's most recent SCOC MDS, dated 1/16/14, coded:                      -Foley catheter in place for urine.                      -Pain present. Both routine and PRN pain medications needed, as well as non-medication pain interventions.                      -Non-verbal sounds, facial expressions, and protective body movements indicating pain present noted.</p>	F 323		

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

PRINTED: 03/03/2014  
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  C <b>02/14/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 323	<p>Continued From page 79</p> <p>On 12/23/13, time documented as, "AM," a facility "Stop and Watch Early Warning Tool" documented Resident #4 was experiencing increased pain. The form was signed by CNA #3, and documented as given to LN #4. LN #4 signed acknowledgement of the document on 12/23/13 at 9:30 AM.</p> <p>On 12/25/13, a facility "Non-Pressure Ulcer Investigation" form documented: [NOTE: The form documented check boxes for several types of "Skin Issues," such as blister, burn, abrasion, bruise, etc., including an option of "other." None of the boxes on this form were marked.] -"Resident Statement as to Cause, if able:" documented: "[Patient] bed bound 20 [plus] years, Hoyer transfer. Bruising appears somewhat linear - hit against bed rail; position incorrect in Hoyer; struggles during clothing changes are three possible etiologies [related to left upper arm] bruising. One LPN [name] states she gives insulin in that [left] upper arm..." [NOTE: Resident was unable to state the cause of the injury.] -The form documented the resident had poor skin turgor, and was using geri-gloves, chair bolsters, hand splints, quarter side rails, and required Hoyer lift transfers at the time the bruises were discovered. -The resident was documented as "Total Dependence" for transfers.</p> <p>On 12/25/13, an "Addendum: Final X-Ray Report" in the medical record documented Exam Type as, "Portable Shoulder Left." Findings documented, in part, "Acute Proximal humeral fracture noted." The addendum documented, "There is minimal</p>	F 323		

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 323	Continued From page 80 osteoporosis."  A facility "Unusual Occurrence" report for the above fracture, dated 12/25/13, documented, in part: -"Summary of event: On 12/25/13 during cares, resident noted to guard left arm. Licensed nurse examined and noted some faint yellow bruising and swelling, grimacing with gentle touch. Physician notified, x-ray obtained with evidence of acute proximal left humeral fracture." -"Investigation & Conclusion: Upon completion of a thorough investigation...it is determined that on the morning of 12/23/13 [Resident #4] exhibited guarding and pain with morning cares...On the morning of 12/25/13...an x-ray was obtained. X-ray confirms acute proximal left humeral fracture...there is no evidence that [Resident #4] had a fall, hit his arm on anything in the environment, had an inappropriate hoyer transfer, or had any other accident...on 12/22/13, two CNA's provided cares...They report that his t-shirt fits so snugly, so they pulled down the arm of the shirt then lifted his elbow to remove his t-shirt...Investigation indicates...arm was fractured between the evening of 12/22/13 and the morning of 12/23/13. Evidence shows that the fracture was consistent with internal rotation during cares, either during the removal of his shirt or during turning/repositioning while in bed. No specific event was identified. [Resident #4] has significant tone/contractures in his left arm related to his CVA and DJD." -"Plan to Prevent Recurrence...CNA staff re-educated and skills checked on donning/doffing shirts and repositioning for residents with hemiplegia impairments." -The last 2 pages of the report were entitled, "Compilation of Interviews (CI) held on 12/30/13,	F 323			

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

PRINTED: 03/03/2014  
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  C <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 323	<p>Continued From page 81</p> <p>01/01/14, and 01/02/14." The pages contained bulleted summaries of staff interviews related to this event.</p> <p>NOTE: The summaries on these pages were of interviews conducted between 5-7 days after the fracture was diagnosed, and 8-10 days after the initial onset of pain and ROM changes. The summaries did not include statements from the CNA identified to have originally reported the event. The summaries did not identify which CNAs were in the room providing cares when the resident's T-shirt was identified as being too tight, nor describe the technique the CNAs used to remove his shirt in light of this awareness. The content of the interviews for several staff members was attached. Interview statements documented, in part:</p> <p>-12/25/13, CNA #11 documented, "Lots of times when I come on duty he has to [sic] small of shirts on..."</p> <p>-12/25/13, a statement from CNA #7 documented, "I was told on the beging [sic] of my evening shift either on Saturday or Sunday [12/21/13 or 12/22/13] that his arm was sensitive and he was pulling away his arm and crying out. The last time I saw him before I was told this, he showed no signs of being hurt..." This statement was summarized in the CI as, "Worked with resident on 12/21/13 and 12/22/13. No pain or discomfort noted.</p> <p>NOTE: The statement from this CNA identified a possible change in the time frame of Resident #4's injury, to 24-48 hours earlier than the facility had concluded. There was no documented evidence this was investigated. The summarized statement on the CI was not reflective of the CNA's hand-written statement.</p> <p>Resident #4's Care Plan documented:</p>	F 323			

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

PRINTED: 03/03/2014  
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>C</b>  <b>02/14/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 323	<p>Continued From page 82</p> <p>-Focus of, "[R #4] has a fracture of left humerus and dislocated Femoral head fracture to Right leg r/t Severe demineralization of bones, severe osteopeni, Hx of chronic fractures and degenerative changes to bilateral hips/pelvis." Date Initiated 12/28/12, revised on 1/21/14.</p> <p>-Interventions included:</p> <p>***Family requires resident stay in clean hospital gown [every shift] and not be dressed in personal clothing any more." Date initiated 1/21/14.</p> <p>-"Indwelling catheter for comfort to minimize pain caused with mobility and repositioning." Date initiated 2/21/14.</p> <p>-"Resident to remain bed bound per family request to minimze pain and/or further injury from transfer and frequent repositioning." Date initiated 1/21/14.</p> <p>Physician's Progress Notes documented: 12/27/13. [NOTE: This is the first time the resident was examined by a physician since the onset of his pain and mobility changes on 12/23/13, and his diagnosis of an arm fracture on 12/25/13.] "...I had initially been notified on 12/23/13, that the paitent seemed to be having some increased pain to his left shoulder...There was noted to be no signs of injury or reports of injury from the staff,,I was called again on 12/25/13 indicating that the Ultram was not helping and he was having significantly worse pain...An x-ray was obtained on 12/25/13, that showed acute proximal humeral fracture...I did have the nurses go back to see him when he started complaining of the pain and we will try to find out when the fracture actually occurred..." -1/17/14. "...he is quite immobile with his history of stroke and it is somewhat difficult to get his clothes off and on without hurting his arm... He is not eating or drinking very well. He gets a little bit</p>	F 323		

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 323	<p>Continued From page 83</p> <p>sedated with medications so appears to be somewhat dehydrated today..."</p> <p>-1/24/14. "...On 1/19/14, the staff noted that he had some protrusion of the right hip with deformity and seemed to have some pain. An x-ray was obtained which showed a displaced fracture of the right femoral neck...it was felt that the hip fracture was old and nothing new...The patient had a Foley catheter placed for his dignity as well as for the fact that to move him causes severe pain and this needs to be in place for his pain control and quality of life..."</p> <p>Resident #4's interdisciplinary Progress Notes documented:</p> <p>-12/25/13 at 12:20 PM. "Family notified, [daughter] was in bed ill. She did return the call and is quite angry about this, does not appear to be rationale [sic]..."</p> <p>-12/25/13 at 6:08 PM. "Called [daughter] to give her status update...discussed there is an ongoing investigation...Discussed tight fitting clothing, family will be happy to bring in loose clothing..."</p> <p>NOTE: This is the first documentation the resident's family was informed his shirts were too tight, and the first documented request for looser clothing.</p> <p>-1/1/14 at 10:40 AM. "...is not eating and drinking as usual. Continues to appear in some pain due to fx..."</p> <p>1/3/14 at 1:53 PM. "...T-shirt cut off due to being too painful to put on, use hospital gowns instead..."</p> <p>-1/19/14 at 3:32 AM. "CNAs were providing incontinence care and noticed a hard area to res[ident's] buttocks that they have not noticed before...Rt side of buttocks was noted to have a bony protrusion. Res noted to have facial grimacing upon palpation...obtained order for</p>	F 323			

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

PRINTED: 03/03/2014  
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>C</b>  <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 323	<p>Continued From page 84</p> <p>STAT portable x-ray..."</p> <p>-1/19/14 at 9:47 AM. "Res sent to [acute care hospital] via ambulance..."</p> <p>-1/19/14 at 12:23 PM. "Pt back from ER...R hip fx is chronic in nature r/t severe osteoporosis, demineralization, osteopenia. Both hips are severely compromised r/t these finding [sic]..."</p> <p>-1/20/14 at 12:43 PM. "...[daughter] notes plan to eliminate option of placing tops/bottoms on res as she will be taking his clothes home today. Notes that MD at hospital indicated to drape gowns over res...Does not want res to get up for all three meals anymore..."</p> <p>A facility Unusual Occurrence report dated 1/19/14, summarized the event as above and further documented, as part of the Plan to Prevent Recurrence, "Staff is educated on new diagnosed disease process, fracture care, hip precautions, and updates to care plan for fracture prevention."</p> <p>On 2/11/14 at 1:20 PM, during an interview, the resident's representative stated:</p> <ul style="list-style-type: none"> <li>-They understood the hip fracture to be pathological, but continued to have concerns regarding the arm fracture.</li> <li>-The facility said the root cause of the arm fracture was tight-fitting T-shirts. The facility had not asked the family, either before or after the arm fracture, to provide larger T-shirts.</li> <li>-The facility had been unable to explain how they had ruled out whether someone had twisted, pulled, or forcibly lifted the resident's arm.</li> <li>-The resident's shirts were removed only after the facility placed metal fasteners on the backs of his shirts, because they were concerned the fasteners would cause skin breakdown.</li> </ul>	F 323			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 323	<p>Continued From page 85</p> <p>On 2/12/14 between 12:45 PM and 2:45 PM, the DNS and DDCO were asked about Resident #4's fractures.</p> <p>-The DNS initially stated the root cause of R #4's arm fracture was determined to be severe osteopenia. However, the DNS agreed the facility did not know about this diagnosis until after the resident's hip fracture was discovered 26 days later.</p> <p>-The DNS stated the facility had not informed the family of the need for larger shirts prior to the fracture, as it had not been identified as an issue before that time.</p> <p>-The DNS was unable to address whether or not other possible causes of the fracture - such as side rails or the mechanical lift - had been ruled out as causes, since those items were identified in the original incident report. NOTE: The facility was twice asked to produce a side rail safety assessment for Resident #4, but ultimately did not provide that document.</p> <p>On 2/13/15 at 10:50 AM, the DNS and DDCO met again with the surveyor. They stated:</p> <p>-While the nurse who wrote the original incident report mentioned the mechanical lift and the side rails as possible contributing factors, the facility felt they could rule those out because the first symptom which presented was pain, and there was no evidence of trauma.</p> <p>NOTE: They were unable to explain how the bruising which developed on the arm, or the sudden change in mobility of the arm, were not evidence of trauma.</p> <p>-During interviews, the staff stated the resident's T-shirts had been too tight, but they would never "force" to get one on.</p> <p>-They reported the orthopedic physician had stated, after the hip fracture was discovered on</p>	F 323		

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 323	<p>Continued From page 86</p> <p>1/19/14, the resident could sustain a fracture from something as simple as rolling over in bed. -However, the DNS and DDCO also stated there was no way the fracture could have come from anyone pulling on, twisting, or lifting his arm. They were unable to offer another explanation as to how the fracture may have occurred. -Even though the original incident report identified the resident as bed-bound, the DNS stated, "He was not that fragile at the time of the arm fracture. He was still getting up to the dining room for meals and everything."</p> <p>Resident #4 was harmed when he sustained a left humeral fracture while a resident in the facility. There was a 2 day delay between the onset of pain, and the diagnosis of the fracture. The facility's investigation did not include statements from all pertinent staff, nor did it rule out all possible identified causes. In fact, the statements obtained during the investigation suggested the fracture may have occurred a full 24-48 hours prior to the timeline the facility had identified, but this was not explored. While the conclusion of the facility's investigation was ultimately that his T-shirts were too tight, there was no evidence the facility had identified this in advance, or requested the resident's family to supply larger clothing. The facility concluded their investigation with no clear picture as to how applying a shirt to the resident, which had been a normal part of his daily routine for years, was suddenly traumatic enough to cause a fracture. Following the fracture of his arm, Resident #4 developed pressure areas from the sling applied, experienced increased pain, developed increasing difficulty with alertness and swallowing, became dehydrated, and had to wear hospital gowns rather than regular clothing.</p>	F 323		

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 323	<p>Continued From page 87</p> <p>Please see F309 as it pertains to pain and delay in treatment, F314 as it pertains to the development of pressure ulcers, and F327 as it pertains to dehydration.</p> <p>4. Resident #5 was readmitted to the facility on 10/1/11 with multiple diagnoses including dementia without behavioral disturbances and hypertension.</p> <p>On 2/10/14 at 1:24 PM, quarter side rails on both upper sides of the resident's bed were observed in the upright position. On 2/11/14 at 11:02 AM, the resident's bed was observed again and there were no side rails attached to the bed.</p> <p>The resident's Bed Safety Evaluation dated 2/4/14 documented the resident had two quarter rails but did not document if the resident was evaluated for safety with the side rails.</p> <p>The resident's Physicians Orders and care plan did not address the side rails prior to the observation on 2/10/14. A physician telephone order on 2/10/14 at 6:00 PM, documented, "DC [discontinue] side rails."</p> <p>On 2/13/14 at 3:30 PM the DON and DDCO were interviewed regarding the side rails. When asked if the resident had been assessed for side rail safety on 2/4/14 during the Bed Safety Evaluation, she stated, "No." She explained at that time the resident's bed did not have side rails, but sometime between 2/4 and 2/10/14, the resident received a new bed from the maintenance department, which had side rails attached to it and the DON was unaware of the switch until after the survey team observed the</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 88 room.	F 323		
F 327 SS=D	<p>On 2/13/14 at 6:05 PM the Administrator, DON, DDCO, and Divisional Vice-President were informed of the issues. No further information was provided by the facility.</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</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 provide hydration needs for 2 of 15 (#4, #8) sampled residents. The deficient practice had the potential to cause more than minimal harm when resident #8 had a diagnosis of dementia, and staff failed to provide hydration during cares, did not cue the resident to drink, and fluids were not within reach for the resident. Resident #4 required staff assistance and thickened fluids. Staff did not provide hydration per plan of care and thickened fluids were not readily available. Findings included:</p> <p>1. Resident #8 was admitted to the facility on 2/19/06 with diagnoses that included, senile dementia, osteoarthritis and depressive disorder.</p> <p>The resident's Quarterly MDS, dated 11/14/13, documented: *BIMS: 1- severely impaired. *Eating: 3- 2, extensive assistance, one person.</p>	F 327	<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><b>F327</b> <b>Resident Specific</b> ID Team rounds verify that water is available, resident cued for consumption, and fluids provided per plan to residents # 4 and 8.</p> <p><b>Other Residents</b> Clinical Management and Registered Dietician (RD) reviewed residents on thickened liquids and fluid enhancement plans for adequate hydration. Care plans were adjusted as indicated.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605	
(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 327	Continued From page 89  The resident's Physician Orders, dated 2/1/4 through 2/28/14, documented: *Diet: LCS (low concentrated sweets). Texture: Mech(anical) soft. Liquids: Thin. Start date: 5/28/13. *Fluid Enhancement: Offer 180 cc water (with)/med pass QID (four times a day) to total an extra 720 cc of H2O(water) per day R/T (related to) HX (history) of UTI's (urinary tract infections.) Start date: 12/6/06. *Nutritional supplement 60 cc po (by mouth) TID (three times a day) (with)/ meds. Dx (diagnosis):supplement. Start date: 12/28/12.  The resident's Medical Nutrition Therapy Assessment dated 7/12/12, documented: *Estimated needs: Fluid 2000 (ccs). NOTE: This was the assessment provided by the facility during the survey. On 2/14/14 at the Exit conference a form numbered, page 14 of 23, was provided. There was no date, or type of form provided. Resident's name was on the form and documented: "Total fluid estimated needs: 2200."  The resident's Care Plan Conference Summary, dated 11/6/13, documented; *Risks/Consequences: "Fully dependent upon others to initiate (and) carry out ADL's(activity of daily living.)"  The resident's Medical Nutrition Therapy Review, dated 11/11/13, documented: *Nutrition Diagnosis and Results: -Nutrition Diagnosis #1: "Swallowing difficulty." -Nutrition Diagnosis #2: "Inadequate oral intake."  The resident's Care Plan documented: *Focus: "Pt. is at risk for increased oral infection	F 327	<b>Center Systems</b> SDC and/or DNS has educated clinical staff regarding maintaining resident hydration to include but not limited to, fluids with medication administration, fluids accessible and offered at bedside, cuing during meals, thickened liquids available at the bedside, and following care plan interventions for fluid enhancement. Hydration status is reviewed through rounds, record review, upon admission, and with change of condition.  <b>Monitor</b> The DNS and/or designee will make rounds three times weekly and audit residents for fluid offerings and consumption. Four residents will be reviewed weekly for 4 weeks, then 2 residents weekly for 4 weeks. Starting the week of March 17, 2014, documentation will take place on the PI Audit Tool. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.  <b>Date of Compliance</b> March 21, 2014	

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 327	<p>Continued From page 90</p> <p>secondary to severely impaired swallow function."Date initiated: 5/1/13</p> <p>*Interventions: -"Regular water will be available bedside with oral swab as needed for oral satisfaction." Date initiated: 5/1/13</p> <p>*Focus: "(Resident's name) has GERD (Gastroesophageal reflux disease) r/t (related to) GI (Gastrointestinal) upset with meals. Date initiated: 7/16/13</p> <p>*Interventions: -"Avoid overeating. Provide small frequent meals rather than 3 large ones. Encourage the resident to take their (sic) time eating. Alternate food with sips of fluid." Date initiated: 7/16/13</p> <p>*Focus: "(Resident's name) has bladder incontinence r/t Dementia, Impaired mobility, Activity intolerance." Date initiated: 10/15/13</p> <p>*Interventions: -"Encourage fluids during the day to promote prompted voiding responses." Date initiated: 10/15/12 -"Limit fluids 2-3 hours prior to bedtime." Date initiated: 10/15/12</p> <p>Focus: "(Resident's name) is at risk for nutritional decline related to: acute illness, difficulty chewing, restrictive or mechanically altered diet, Depression, increased risk for dehydration, progressive dementia, Wt (weight) loss beneficial r/t DM (Diabetes Mellitus) 2" Date initiated: 11/21/12. Revision on: 5/1/13</p> <p>*Interventions: -"Provide verbal cueing ie: continue eating (res[ident] tends to nod off.)" Date initiated: 11/21/12</p>	F 327			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 327	<p>Continued From page 91</p> <p>The resident's MAR and the Flow Sheet record, dated January 2014, documented the resident's average fluid intake with meals was 840cc of fluid. The resident's "Fluid Enhancement" daily average was 360cc. The resident's "Nutritional Supplement" was 180cc total per day. The documented daily average fluid intake for the resident was 1380cc, with the resident's assessed need to be 2200cc.</p> <p>On 2/11/14 at 8:05 am, the resident's facility water container was on the dresser at the foot of her bed. It was full.</p> <p>On 2/11/14 from 8:07 am to 8:30 am, the resident was observed in the Paradise dining room, eating breakfast. The resident had a cup of milk, a cup of juice and a carton of milk in front of her. During the observation, the resident was cued to drink fluid one time by her family member at 8:17 am. Staff in the dining room did not cue resident to drink the fluids. When the resident was taken from the dining room at 8:30 am, she had drank the juice and the carton of milk was used in the hot cereal. The resident had consumed 340cc of fluid.</p> <p>On 2/11/14 at 8:35 am, the resident was observed in her room in her w/c (wheelchair) in front of her TV. The resident's water container was on the dresser, full. The water was 4 feet from the resident, not within reach of the resident.</p> <p>On 2/11/14 at 8:55 am, position of the resident and water was unchanged. At 9:00 am, LN #21 provided cares for the resident. The LN positioned the resident in her w/c closer to the resident's bed. LN#21 did not offer water to the resident while in the room. The water container</p>	F 327			

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(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 327	<p>Continued From page 92</p> <p>was now positioned farther from the resident. LN#21 offered water to the resident's roommate prior to leaving the room.</p> <p>On 2/11/14 at 9:38 am, the resident's position remained unchanged, and the water container was full. CNA #27 and CNA #28 were in the room providing cares for the resident's roommate.</p> <p>On 2/11/14 at 10:00 am, CNA #27 and CNA #28 assisted the resident to the toilet using the sit to stand. CNA #27 was asked if the resident's incontinence brief was wet, the CNA stated, "not very much, maybe one time." At 10:12 am when the resident was taken from the bathroom, CNA #27 was asked if the resident had urinated in the toilet, the CNA stated, "No, she peed a little bit." At 10:16 am, the resident was taken in her w/c to sit in the hall. The resident's water container remained full, on the dresser and the CNA's had not offered fluids during cares.</p> <p>On 2/11/14 at 11:03 am, the resident was sitting in the hall next to her room.</p> <p>On 2/11/14 at 12:10 pm, the resident's water container was full sitting on the resident's dresser.</p> <p>On 2/11/14 at 12:20 pm through 12:40 pm, the resident was in the Paradise dining room. The resident had apple juice, tomatoe juice, water and coffee on the table in front of her. During the observation the resident was offered juice 1 time, and coffee 3 times. The resident was not offered the water. CNA #5 offered the resident the coffee, then handed it to the resident, which she drank. At 12:40 pm, the resident was taken from the dining room and positioned outside of her room.</p>	F 327			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 327	<p>Continued From page 93</p> <p>CNA #5 verified the amount of cc's each cup and container, contained. CNA #5 verified the resident had consumed 220cc's of fluid at the noon meal.</p> <p>On 2/11/14 at 12:45 am, the resident was observed dozing in her w/c by the door of her room. At 12:50 pm, LN #29 provided the resident with her medications in applesauce. Water was provided in a plastic cup to swallow the medications, the cup was approximately 1/4 full. The resident took a sip of the water. LN#29 encouraged the resident to drink more of the water, the resident stated, "Oh, yes," and took the cup and readily drank it. The amount in the cup was verified with LN#29. LN #29 poured 3 of the 30cc medicine cups in the same type plastic cup used for the resident, the total offered was approximately 90cc's.</p> <p>On 2/11/14 at 2:00 pm, and 2:52 pm, the resident was observed asleep in her bed. The water container was on the dresser, full, out of reach of the resident.</p> <p>On 2/11/14 at 3:15 pm, the resident was observed in bed asleep. The water cup was moved to the edge of the dresser, and contained ice water. The cup was full, and out of reach of the resident.</p> <p>On 2/12/14 at 12:10 pm, the resident's water cup was observed full and on the resident's dresser. The resident was in the Paradise dining room, dozing in her w/c. On the table in front of her was a full cup of coffee, and a full cup of water. Staff were not cueing the resident.</p> <p>On 2/12/14, from 12:45 through 1:12 pm, the resident remained in the Paradise dining room in</p>	F 327		
-------	---	-------	--	--

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 327	<p>Continued From page 94</p> <p>her w/c. The resident's coffee cup was observed to be 3/4 full, the water cup was full and there was a full cup of apple juice on the table in front of the resident. At 12:55 pm, CNA #30 sat down with the resident and offered her food and fluids, the resident stated, "No," to the offers. At 1:04 pm, CNA #30 picked up the resident's coffee and gave her a drink. The resident stated, "That is good," and the resident continued drinking the coffee, while CNA #30 assisted her in drinking it. The resident was taken from the dining room at 1:12 pm and positioned in the hallway by the door to her room. The only liquid the resident consumed for lunch was coffee.</p> <p>On 2/12/14 at 1:15 pm, the surveyor observed CNA #5 and CNA #19 taking the resident into her room and providing cares before putting her to bed. Fluids were not offered to the resident.</p> <p>On 2/12/14 at 3:38 pm, the resident was observed asleep in bed. The resident's water container was on the dresser out of reach of the resident. The cup was full, with cold ice water.</p> <p>On 2/12/14 at 4:37 pm, the resident was observed in her w/c in the hall. The resident's water cup was full, positioned next to the TV.</p> <p>On 2/12/14 at 6:45 pm, a CNA was observed walking out of the resident's room. The resident was in bed. The resident's water container had approximately 100cc's drank from it, the straw was not present, and it was positioned on the TV stand out of reach of the resident.</p> <p>On 2/13/14 at 10:07 the findings were discussed with the DON and DDCO. The DDCO stated, "You obviously have a lot of observations, but we</p>	F 327		

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

PRINTED: 04/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 327	<p>Continued From page 95 will see what we can do."</p> <p>On 2/13/14 at 6:15 pm, the Administrator, DON, and DDCO were informed of the findings. On 2/14/14 at the Exit conference additional information was provided, which did not change the findings.</p> <p>2. Resident #4 was admitted to the facility on 4/25/08 with multiple diagnoses which included hydrocephalus with the placement of a VP shunt, right-sided CVA with left hemiparesis, diet controlled DM, osteoarthritis, and chronic pain.</p> <p>Resident # 4's most recent Significant Change of Condition MDS assessment, dated 1/16/14, coded severely impaired cognitive skills, and total dependence on staff for eating.</p> <p>Resident #4's Physician's Orders (Recapitulation Orders) for February 2014 documented the resident required honey thick liquids.</p> <p>Resident #4's Care Plan documented: -Focus area, "...risk for malnutrition r/t requires...thickened liquids." Date initiated 7/25/13, revised on 10/16/13. -Intervention of, "Offer thickened fluids between meals." Initiated 1/21/14.</p> <p>On 2/10/14, at 10:00 AM, the resident was observed laying on his bed, in his room. There were no fluids noted in the room. This observation was repeated at 1:50 PM, 2:40 PM, 3:20 PM, and 4:10 PM. No staff were observed to</p>	F 327			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 327	<p>Continued From page 96</p> <p>enter his room to offer fluids during any of those observations.</p> <p>On 2/11/14 at 9:35 AM, CNA #s 31 and 32 were observed providing care to Resident #4. No fluids were available in the room, and the CNAs were not observed to offer the resident fluids.</p> <p>On 2/11/14, between 12:20 PM and 12:40 PM, CNA # 31 was observed assisting the resident to consume his lunch meal. The resident readily drank a glass of thickened juice, and a glass of thickened water, and at times rejected bites of food in apparent favor of waiting for fluids to be offered. After the juice and water had been consumed, CNA #31 stated to the resident, "Do you want more water." The resident nodded his head. The CNA then stated, "He's on thickened liquids, so I have to go out and get the water for him." The CNA then left the room, was gone for approximately 5 minutes before returning. The resident readily accepted the offer of more thickened water.</p> <p>On 2/12/14 at 12:45 PM, the DNS and DDCO were asked about the surveyor's observations. The DNS stated, "Water is available, we have the boxes of thickened water in the fridge. All they [staff] have to do is come out and get it."</p> <p>On 2/13/14 at 6:30 PM, the Administrator, DNS, and DDCO were informed of the surveyor's findings. The facility offered no further information.</p>	F 327		
F 329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from</p>	F 329		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605	
(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 97</p> <p>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.</p> <p>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 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, it was determined the facility failed to ensure residents who received psychopharmacological and antibiotic medications: *Had adequate indications for its use; *Received gradual dose reductions (GDR); *Received adequate risk and benefit information; *Had identified which nonpharmacological interventions were attempted; and *Were adequately monitored. These failures created the potential for harm</p>	F 329	<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><b>F329 Resident Specific</b> Resident # 5: family has been informed of antipsychotic &amp; antidepressant black box warning, GDR initiated for Risperdal, and the transcription error is corrected with sleep monitor established for Trazodone. Resident # 9: family has been informed of black box warning of antipsychotic, GDR taper is in place with discontinuation anticipated for 03/28/14.</p> <p><b>Other Residents</b> ID Team reviewed residents with dementia on antipsychotic and hypnotic medications. Families were informed of black box warning, indication for use and GDR's were reviewed, target behaviors and non-drug interventions were updated as indicated.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605	
(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 98</p> <p>should the medication regimen result in an unanticipated decline or newly emerging or worsening symptoms. This was true for 2 of 13 sample residents (#5, and 9). Findings included:</p> <p>1. Resident #5 was readmitted to the facility on 10/1/11 with multiple diagnoses including dementia without behavioral disturbances and depression.</p> <p>a. The resident's annual MDS assessment, dated 7/22/13, and quarterly MDS assessment, dated 11/21/13, documented the resident did not have any physical, verbal, or other behavioral symptoms directed towards others.</p> <p>The resident's February 2014 MAR documented an order dated 3/14/13 for, "Risperdal 0.25 MG PO Q[every] AM &amp; 1500 [3:00 PM]..." with a diagnosis of dementia related psychosis.</p> <p>The resident's Acknowledgment of Psychoactive Medication Use, dated 4/14/12 documented on the resident's previous admission, the resident's family consented to the use of the Risperdal with potential risks and benefits. The documentation did not include a black box warning of death for the use of antipsychotic medication in the elderly. At the time of survey, the resident was 94 years old.</p> <p>The resident's December 2013-February 2014 Monthly Behavior Summary were reviewed and documented the resident expressed "physical aggression," four times in December, eight times in January, and zero times in February.</p> <p>On 2/13/14 at 3:30 PM the DON and DDCO were interviewed regarding the black box warning and</p>	F 329	<p><b>Center Systems</b></p> <p>SDC, DNS, and/or DDCO has educated social services and nursing staff regarding psychoactive drug use in residents with dementia to include but not limited to,</p> <ul style="list-style-type: none"> <li>▪ Adequate indication for use</li> <li>▪ Gradual dose reductions</li> <li>▪ Black box warnings</li> <li>▪ Behavior monitors that capture how resident is a harm to themselves or others</li> <li>▪ Non-pharmacological interventions</li> <li>▪ Trazadone for sleep to include a sleep monitor</li> </ul> <p>Psychoactive drug use is reviewed on admission, within 14 days of admission, monthly, and with a change of condition by Clinical Management team and/or ID Team.</p> <p><b>Monitor</b></p> <p>DNS and/or designee will review new psychoactive drug orders weekly to validate indications for use, consent to include black box warning, and initiation of appropriate behavioral monitoring. Residents with dementia who are on psychoactive drugs will be reviewed for gradual dose reduction at the monthly behavioral meeting. Behavior monitors will be reviewed for 2 residents for 4 weeks, and then 1 resident for 4 weeks. Starting the week of March 17, 2014, documentation will take place on the PI Audit Tool. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate. <b>Date of Compliance</b> March 21, 2014</p>	

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

PRINTED: 03/03/2014  
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>C</b>  <b>02/14/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 329	<p>Continued From page 99</p> <p>clinical indications for use issues. When asked if the Acknowledgment of Psychoactive Medication Use form documented the family was notified regarding the risk of death of an antipsychotic for the use in the elderly, the DDCO stated, "No." When asked what physical aggression was the facility monitoring, the DDCO stated the resident, "Hits out on staff," when providing cares, especially incontinent care. When asked if the resident hit or was physically aggressive toward other residents, the DON stated, "No." When asked if the resident hurt himself, the DON stated, "No."</p> <p>The facility failed to provide the family adequate risks associated with the use of antipsychotic medication and to provide an appropriate indication for its use.</p> <p>b. A Physician Progress note dated 3/14/13, documented the resident, "...is quite demented and nearly non-communicative today- am not at all sure the med[ication]s he is on help at all and propose to begin tapering them -will start with Risperdal (reduce to once/d[ay]) and go from there -will see him again in 2 mo[nth]s -facility will let me know if any changes."</p> <p>A Physician's Telephone Order dated 3/14/13 at 3:15 PM, documented, "Change Risperdal to 0.25 mg Q 1500 [3:00 PM] only F/U [follow up] 2 mos."</p> <p>A Physician's Telephone Order dated 3/14/13 at 4:35 PM, documented, "1. Risperdal 0.25 MG PO Q AM &amp; 1500...2. disregard prior order to [reduce] Risperdal."</p> <p>Note: The progress note and both telephone orders were made by the same physician.</p>	F 329		

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 329	<p>Continued From page 100</p> <p>The resident's March 2013 MAR documented an order dated 6/28/12 for, "Risperdal 0.25 MG PO Q AM &amp; 1500 ..." with a diagnosis of dementia related psychosis.</p> <p>The resident's February 2014 MAR documented an order dated 3/14/13 for, "Risperdal 0.25 MG PO Q AM &amp; 1500 [3:00 PM]..." with a diagnosis of dementia related psychosis. Note: This is the same dosage as the 6/28/12 order.</p> <p>On 2/13/14 at 3:30 PM the DON and DDCO were interviewed regarding the medication order issue. The DDCO said the physician who made the progress note had just taken over care from another physician for his primary care. The new physician did not know at that time, the resident had a different physician involved in the resident's antipsychotic medication care, which is why the physician changed the order back to the original order dosage. The DDCO also said the GDR was not due to be looked at until June 2013, however, she stated, "We missed the GDR in June." When asked why the GDR was missed in June, the DDCO said because when the physician changed the order on 3/14/13 it appeared to have been looked at for a GDR, but it had not.</p> <p>c. A Physician Progress note dated 12/12/13 documented under the Assessment/Plan section: "Insomnia. The patient is apparently having some issues with sleep during the evening hours. We will go ahead and give the patient Trazodone 25mg 1 tablet QHS [at hour of sleep] and see if this helps with his sleep."</p> <p>A Physician's Telephone Order dated 12/12/13 documented the order as above.</p>	F 329			

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

PRINTED: 03/03/2014  
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>C</b>  <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 329	<p>Continued From page 101</p> <p>Resident #5's December 2013 MAR documented on 12/12/13 a handwritten order, "Trazodone 25mg 1 Tab[let] PO [by mouth] QHS Insomnia." Below the note was another handwritten note documented, "Chart h[ou]rs of sleep Q shift," and had sections filled in where sleep was recorded for each shift from 12/13 through 12/31/13.</p> <p>The resident's care plan had a Focus documented on 12/13/13 for, "Impaired Sleep Pattern r/t: Insomnia." The care plan interventions documented on 12/13/13, "Administer medications as ordered. See medication record. Monitor effectiveness and side effects."</p> <p>The resident's January and February 2014 MAR did not include an area on the MAR to record hours of sleep for the resident.</p> <p>On 2/13/14 at 3:30 PM the DON and DDCO were interviewed regarding the monitor for hours of sleep issue. When asked if the hours of sleep were recorded for January and February, the DDCO stated, "There was not."</p> <p>2. Resident #9 was admitted to the facility on 9/3/11 with multiple diagnoses including Alzheimer's dementia.</p> <p>Resident #9's most recent Annual MDS assessment, dated 12/3/13, coded moderately impaired cognition, no hallucinations or delusions, no verbal or physical behaviors directed towards self or others, and no rejection of cares.</p> <p>Resident #9's care plan documented a Focus area of, "...uses psychotropic medications r/t dementia with associated behavioral symptoms, depression." Date initiated 9/25/12, revised on</p>	F 329		

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 329	<p>Continued From page 102</p> <p>8/30/13. The goals and interventions for this focus area did not include specific target behavioral symptoms which presented, nor non-medication approaches to be used with the resident.</p> <p>Resident #9's Physician's Orders (Recapitulation orders) for February 2014 documented an order for Seroquel 25 mg at bedtime, beginning 12/28/12 for a diagnosis of dementing illness with associated behavioral symptoms. On 2/5/14, a physician's telephone orders form documented, "Clarify Seroquel Dx to dementia [with] organic mental syndrome."</p> <p>Resident #9's Monthly Behavior Monitoring Flowsheet forms documented, for December 2013, January 2014, and February 2014, a target behavior of "Ref[using] Cares." The values listed for the number of occurrences of this behavior for each shift, each of those months, was "0."</p> <p>On 2/10/14, Resident #9 was observed in her room. She was receptive to having a visitor, pleasantly showed the surveyor her bead collection and the pictures she had been coloring. The resident was cheerfully perplexed that, "My kids came in and took my TV, and left me with this broken picture. Well, sometimes it's broken. Sometimes this thing helps it work," while gesturing to the flat-screen television mounted to her wall, and the remote control.</p> <p>On 2/13/14 at 4:50 PM, the DNS and DDCO were asked about the indication for Resident #9's Seroquel use. When shown the behavior monitor and physician's order, the DDCO stated, "It looks like refusing cares. I guess the question is, how is that harmful to herself or others. And what other</p>	F 329			

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605	
(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 103 things we had ruled out, such as pain. We attended the in-service (on psychotropic medications) a couple of weeks ago, and we knew we were going to have to fix this. We just hadn't completed it yet. Consider us informed."  On 2/13/14 at 6:30 PM, the Administrator, DNS, and DDCO were informed of the surveyor's findings. The facility offered no further information.	F 329		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and review of facility protocols, it was determined the facility failed to ensure residents received their morning medications timely on the 200 Hall and as ordered by the physician. This was true for 11 of 30 medications (38.7%) and it affected 2 of 8 residents (#17, 18), during medication pass observations. Failure to obtain blood pressure parameters prior to administering blood pressure medication, ensure the correct dose of a nasal spray, administer the appropriate form of aspirin and ensure timely medication delivery created the potential for residents to receive less than optimum benefit from their prescribed medications. Findings included:  The facility's Resident-Centered Medication Pass Protocols, documented:	F 332	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.  F332 <b>Resident Specific</b> SDC and/or DNS rounds show resident # 17 and 18 has their medication provided timely as ordered and with parameters.  <b>Other Residents</b> SDC and/or DNS observation show medication pass is provided as ordered, with parameters, and in a timely manner.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(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 332	<p>Continued From page 104</p> <p>1. Routine medications are given close to meals times: -a. AM (morning) - around breakfast; -b. NOON - around lunch; -c. PM (evening) - around dinner.</p> <p>3. Other guidelines are as follows: -c. QD (every day) - AM dosing will include cardiac medications, antihypertensives, diuretics, potassium replacements, GI (gastrointestinal) reflux, respiratory, and hypothyroid treatment; -g. BID (twice a day) - AM and PM.</p> <p>1. On 2/13/14 at 9:20 am, LN#23 was standing at the medication cart in the 200 Hall. When the surveyor asked the LN if she was passing medications, the LN stated "I am the (stated LN position) today but we had a shortage today, so I am helping out. Usually there is a nurse from 6:00 AM until 6:00 PM. Another nurse is coming in at 9:00 AM. I am all done with the medications for now; the next pass is at noon."</p> <p>On 2/13/14 at 11:15 AM, LN#22 was observed dispensing medications scheduled for morning pass on the 200 Hall. When asked about the late medications, the LN stated, "Yes, we are way behind. I don't know what happened before I got here. Because they are late we have to call the doctor and tell him."</p> <p>a. Random Resident #17 had diagnoses that included dementia, hypertension, spinal stenosis, glaucoma, and chronic pain.</p> <p>The resident's Physician Orders, dated 2/1/14 through 2/28/14, documented:</p>	F 332	<p><b>Center Systems</b> SDC and/or DNS has re-educated licensed nursing staff regarding medication administration guidelines to include but not limited to, correct form of medication, correct dose of medication, parameters completed prior to medication administration, and timeliness of medication administration. Additionally, if unusual occurrences arise, licensed nursing staff is to communicate anticipation of not completing medication pass timely so that support can be provided to prevent tardy distribution. When unusual circumstances occur, administrative nurses participate in assisting with medication pass as necessary.</p> <p><b>Monitor</b> The SDC and/or designee will complete observations of medication administration for one licensed nurse per week for 8 weeks. DNS and/or designee will communicate with licensed nurse to validate anticipated timely completion of medication pass two shifts per week for 4 weeks, then 1 shift per week for 4 weeks. Starting the week of March 17, 2014, documentation will take place on the PI Audit Tool. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p> <p><b>Date of Compliance</b> March 21, 2014</p>	

updated [Signature] Executive Director  
4/3/14

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014	
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(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 332	<p>Continued From page 105</p> <p>*Methadone 5 mg (milligrams) 1/2 tab (tablet) po (by mouth) every AM. Dx. (Diagnosis): low back pain.</p> <p>*ASA (aspirin) 81 mg po QD (daily) W/(with) food. Dx. clot prevention.</p> <p>*Lasix (Furosemide) 40 mg po QD. Dx. edema.</p> <p>*Flonase 2 sprays Q nostril QD. Dx: rhinitis.</p> <p>*Timoptic 0.25% QAM OU (both eyes) 1 GTT (drop). Dx: glaucoma.</p> <p>On 2/13/14 at 11:15 am, LN#22 was observed dispensing the following morning medications for Resident #17: methadone, furosemide, and an enteric coated aspirin, with Flonase and the Timoptic eye drops. The LN went into the resident's room and administered the pills, which the resident took, the eye drops and 1 spray to each of the resident's nostrils. The LN#22 returned to the medication cart, and when asked about the nasal spray, the LN#22 verified giving 1 spray instead of the ordered 2 sprays.</p> <p>NOTE: When the medications were reconciled with the physician's orders, the orders did not document the Aspirin to be given as enteric coated. The medications per the facility protocol and physician orders should have been provided around breakfast time.</p> <p>b. Resident #18 had diagnoses that included diabetes mellitus type 2 (DM) and hypertension (HTN).</p> <p>The resident's Physician Orders, dated 2/1/14 through 2/28/14, documented:</p> <p>*Metformin HCL 1000 mg po BID give with food. Dx: DM.</p> <p>*Coreg (Carvedilol) 12.5 mg po BID give with</p>	F 332		

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 332	Continued From page 106 food. Dx: HTN (hypertension). *Lisinopril 20 mg po QD hold for SBP (systolic blood pressure) (less than) 115. Dx: HTN. *KCL (potassium chloride) 10 mEq (milliequivalent) po QD. Dx: supplement. *Lasix (furosemide) 40 mg po QD. Dx: edema. *Amaryl (Glimepiride) 4 mg po BID. Dx: DM.  On 2/13/14 at 11:30 am, LN#22 was observed dispensing the resident's medications to the resident. The resident took the medications. When asked if the medications dispensed were the resident's morning medications, the LN stated, "Yes, these are his morning medications." LN#22 had not taken the resident's B/P (blood pressure). When the surveyor reconciled the medications with the physician's orders, the blood pressure parameters were noted.  The resident's B/P was not taken prior to receiving the Lisinopril and the resident's morning medications were given late at 11:30 am. The medications per the facility protocol and physician orders should have been provided "around" breakfast time.  On 2/13/14 at 3:29 pm, the Medication Administration Record and the LN Daily Sheet, were reviewed with LN#12, who verified there was not documentation of Resident # 18's B/P. LN#12 stated, "LN#22 didn't do it. (Resident #18's) AM medications are usually [given] at 9:00 AM or 9:30 AM."	F 332			
F 353	483.30(a) SUFFICIENT 24-HR NURSING STAFF	F 353			

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST	STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605
---	--

(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 353 SS=E	<p>Continued From page 107 PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on a resident group interview, record review, observations, and ombudsman, resident, family and staff interviews, it was determined the facility failed to ensure there was adequate staffing to provide for the needs and well-being of all residents. This affected 1 of 13 sampled residents (#7), 1 Random Resident (#21) and 12 of 15 residents who attended the group interview. And, it had the potential to affect all other residents who lived in the facility who required staff assistance with their ADLs. This failure created the potential for psychosocial and</p>	F 353	<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><b>F353 Resident Specific</b> ID Team rounds show resident # 7 and 21 have call lights responded to timely. Interviews show that resident # 7 and 21 state that their call lights are answered timely.</p> <p><b>Other Residents</b> ID Team completed resident interviews to understand care concerns. Adjustments were made as indicated.</p> <p><b>Center Systems</b> SDC, DNS, and/or ED has re-educated staff regarding meeting of resident needs to include but not limited to, call light answering responsibility belongs to the whole team, medication pass time parameters to be met, timely assistance out of bed and with care needs, timely toileting, and timeliness of hot meals. The ED and/or DNS will communicate with the center recruiter for timely filling of staffing vacancies. The SDC and/or designee will provide orientation and mentorship to on-</p>	
---------------	---	-------	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605	
(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 353	<p>Continued From page 108 physical harm to the residents in the facility. Findings included:</p> <p>1. Observations:</p> <p>a. On 2/11/14 at 9:38 AM, Random Resident #21's call light was activated. At 9:40 AM the Activity Aide (A.A.) came in the room. Resident #21 stated, "I have to go to the bathroom, asked about 45 minutes ago." The A.A. left the room and at 9:41 AM came back to the room with CNA #31, who assisted him with resident cares. The A.A. stated, "I haven't done this in a while since I went to activities."</p> <p>Please refer to F332 regarding a delayed medication pass due to low staffing levels.</p> <p>2. Documentation:</p> <p>On 2/10/14 the facility grievance file was requested. Upon review, the following complaints were documented:</p> <p>a. On 11/15/13 a Complaint/Grievances from a resident documented, "Res[ident] noting this am's [sic] routine pain med[ication]s were 1 1/2 [hours] late. Notes call light response consistently poor though have been times when he could not reach call light as it was clipped to the curtain." The Department Response section of the form documented, "Education given to RN Supervisor. Education to staff-proper call light placement &amp; answering call lights." The Resolution Date section of the form was left blank, but did contain a narrative on 11/22/13 of, "Staff education."</p> <p>b. On 12/31/13 a Complaint/Grievances from a resident's family documented, "Res c/o</p>	F 353	<p>board staff effectively. The DNS/SDC will observe and communicate with new hires periodically to validate skill sets. The ED will conduct special resident council meetings to validate concerns are being met. The ID Team will conduct resident interviews regarding care and services to meet resident needs. The DNS and/or designee will continue to oversee staffing on a daily basis and address staffing vacancies as they occur. The ED and DNS will review current staffing patterns/practices for appropriate deployment.</p> <p><b>Monitor</b> The ED and/or designee will monitor recruiting efforts, staff on-boarding, and interview residents regarding timeliness of meeting resident needs. Four residents will be reviewed weekly for 2 weeks, then 2 residents weekly for 4 weeks. The ED will participate in special resident council meeting weekly for 4 weeks, then every other week for a total of 8 weeks. The DNS and /or designee will review staff deployment and new hire orientation plans weekly for 8 weeks. Call light response will be monitored 2 shifts per week prior to breakfast and 2 shifts per week following dinner for 2 weeks, and 1 shift per week for each for 4 weeks. Starting the week of March 17, 2014, documentation will take place on the PI Audit Tool. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p>

updated *John S. Hill - Executive Director 4/3/2014*

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014	
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(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 353	<p>Continued From page 109</p> <p>[complained of] call light wait times (ie [that is] sitting 1 [hour plus] on commode)...family visited 12-28 [at] noon &amp; res had not been toileted or gotten out of bed/dressed-was told not enough staff."</p> <p>The Department Response section of the form documented on 1/4/13, "Call light Audits, placement checks. Education given to staff." The Resolution Date section of the form documented on 1/13/14, "Call light audit. Education to staff."</p> <p>3. Resident Interviews:</p> <p>a. On 2/10/14 and 2/11/14 at 1:59 PM and 8:40 AM respectively, Resident #7 was interviewed. When asked about the staff issues, the resident stated, "I really like them, we are losing a lot of really good people, the ones we are losing are very good." When asked about call light response times the resident stated, "I have to get up to the bathroom and need to get help." When asked about wait times she stated, "A lot of times it takes them a while to get here." When asked if she got impatient she said, "Yes." When asked if the wait times were worse at night she stated, "Yes, it is."</p> <p>b. On 2/11/14 at 10:00 AM during the resident Group Interview, 12 out of 15 residents complained call lights were still an issue. They said they normally waited 15 minutes or longer in the early mornings and evenings. One resident said they needed an extra person from 6:00-10:00 PM. Another resident said she has had to wait up to an hour and a half at times.</p> <p>4. Family Interviews:</p>	F 353	<p><b>Date of Compliance</b> March 21, 2014</p>	

*updated [signature] - John Schukler  
Executive Director  
4/3/2014*

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

PRINTED: 03/03/2014  
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>C</b>  <b>02/14/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 353	<p>Continued From page 110</p> <p>a. On 2/12/14 at 6:50 PM, during a family interview, the family member was asked about staffing levels. When asked if the facility had adequate staff he/she stated, "No, between 4:00 PM and 7:00 PM is probably the shortest." When asked how this affected the resident, he/she said staffing was also a problem during meal times. He/she stated, "The trays get set on a cart an hour and fifteen minutes before they are passed out. I tell them not to put her food on the hall cart because it is 6:00 PM before she eats it and it is cold by then. I like to pick up her food fresh from the kitchen. Sometimes her roommate waits until 6:30 PM to eat. It is a big problem here. There isn't enough people to help. Everyone is doing as good as they can, but we see this problem. The nurses are always very busy; but they do a good job, as good as they can."</p> <p>b. On 2/12/13 at 7:05 PM, during a family interview, the family member was asked about concerns they had. He/she said there were, "Not very many visible people [staff] here at night."</p> <p>5. Ombudsman and Anonymous Source Interviews:</p> <p>a. On 2/10/14 at 1:15 PM, the local Ombudsman was interviewed about concerns. The Ombudsman said their office had complaints about cares being given in a timely manner and slow call light response times.</p> <p>b. On 2/12/14 at 8:52 AM, an Anonymous Source was interviewed about concerns. He/she said when survey staff is at the facility, call lights are also answered by the DON and supervisors, but when survey staff leave, the DON and supervisors do not answer call lights. He/she said</p>	F 353		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(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 353	Continued From page 111 there have been occurrences when residents had been left on the toilet for long periods of time, due to low staff numbers. He/she also said the worst time of day is the 2:00 PM-10:00 PM shift.  6. Staff Interviews:  a. On 2/12/14 at 7:00 PM, CNA #3 was interviewed regarding staff issues. When asked if there was enough help on evening shift, CNA #3 stated, "Yeah, we just have to run a lot."  b. On 2/12/14 at approximately 7:00 PM, CNA #19 was interviewed regarding staff issues. When asked if there was enough help on evening shift, CNA #19 stated, "It would be nice if we had another CNA. Sometimes you get in a resident room and a call light goes off and you just can't get to them."  On 2/13/14 at 6:05 PM, the Administrator, DON, DDCO, and Divisional Vice-President were informed of the staffing issue. No further information was provided by the facility.	F 353			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441	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.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605	
(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 441	Continued From page 112  (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy regarding handwashing, it was determined the facility did not ensure proper hand hygiene during the provision of resident care. Further, a resident in the facility was consuming a meal while sitting on the commode. This was true for 3 of 15 sampled residents (R #s 1, 3, and 4); 3 of 6 Random Residents (#s 16, 19, and 22) 5 CNAs, 2 LNs, and had the potential to impact any other resident with whom those staff came in contact. The deficient practice had the potential to	F 441	<b>F441 Resident Specific</b> Clinical Management Team rounds show hand hygiene and glove use as indicated for resident # 1, 3, 4, 16, 19, and 22. Errors are corrected immediately with re-education and/or performance improvement when indicated.  <b>Other Residents</b> Clinical Management Team rounds provide ongoing observation for hand hygiene and glove use. Errors are corrected immediately with re-education and/or performance improvement when indicated.  <b>Center Systems</b> SDC and/or DNS has re-educated clinical staff regarding hand hygiene and glove use to include but not limited to, during incontinence and catheter care, meal services, and insulin administration. Hand hygiene surveillance reports are completed by the SDC or designee, as well as observations during clinical and ID Team rounds. Staffs that have practice errors are provided timely education; on-going non-compliance will result in written re-education and/or performance counseling.	

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

PRINTED: 03/03/2014  
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>C</b>  <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 441	<p>Continued From page 113</p> <p>cause more than minimal harm if infection were to be spread from unsanitary practices. Findings included:</p> <p>1. On 2/10/14 at 9:20 AM, during the initial tour of the facility, the surveyor knocked on the door of Resident #16's room, and was invited in. The privacy curtain was drawn, but the resident asked the surveyor to "Come on back." The resident was observed sitting in his room on the commode, with his pants down around his ankles. His over bed table was in front of him, over his unclothed lap. His breakfast tray was set up atop the over bed table. Hashbrowns and a fork were visible. He held a cup of coffee in his right hand.</p> <p>On 2/10/14 at 9:40 AM, LN # 12 was informed of the surveyor's observation. The LN stated, "Oh, God. That's not good."</p> <p>On 2/13/14 at 6:30 PM, the Administrator, DNS, and DDCO were informed of the surveyor's findings. The facility offered no further information.</p> <p>2. On 2/11/14 at 9:35 AM, CNA #s 31 and 32 were observed providing cares to Resident #4. After providing catheter care and removing the resident's adult incontinence brief, which was soiled with bowel movement, the CNAs applied a new attends and placed a clean incontinence pad underneath him, touching his peri-area and buttocks throughout. Neither CNA removed their soiled gloves nor washed their hands at any point, either after catheter care, after removing the soiled Attends, or providing clean products. The surveyor asked the CNAs at what point they should have washed their hands or changed their</p>	F 441	<p><b>Monitor</b></p> <p>The SDC and/or designee will complete surveillance rounds on 4 staff weekly for 4 weeks, then 2 staff weekly for 4 weeks. Starting the week of March 17, 2014, documentation will take place on the PI Audit Tool. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p> <p><b>Date of Compliance</b> March 21, 2014</p>		

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

PRINTED: 03/03/2014  
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>C</b>  <b>02/14/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 441	<p>Continued From page 114</p> <p>gloves. The CNAs did not respond for a moment, then CNA # 31 stated, "When we're done?" After a moment, CNA #32 stated, "I think she wants us to say before we put on the clean stuff."</p> <p>On 2/13/14 at 6: 30 PM, the Administrator, DNS, and DDCO were informed of the surveyors observations. The facility offered no further information.</p> <p>3. On 2/10/14 at 11:07 AM, CNA #5 and CNA #18 were observed providing incontinent care for Resident #1. CNA #5 and CNA #18 provided incontinent care, applied barrier cream, and applied a clean brief wearing the same gloves. Staff continued to straighten out the resident's covers, and positioned the resident onto her side with the same gloves used to provide cares. At approximately 11:10 AM, CNA #18 was asked if she changed her gloves, she said, "No." At 11:20 AM, CNA #5 was asked if she changed her gloves while providing incontinent care before putting on a clean brief and touching bed linens. She said, "No I did not; I should have. You guys make me so nervous."</p> <p>On 2/12/14 at 5:30 PM, The Executive Director, DON, DDCO, and Corporate DDCO supervisor were notified of concerns. No further information was received from the facility regarding the issue.</p> <p>4. On 2/10/14 at 12:23 PM in the Paradise dining room, CNA #3 was observed to pick up a rolling stool with both hands and walk it to a table across the room and set it down. The CNA then sat on the stool, did not wash her hands or use hand sanitizer, and then placed her right hand on Random Resident #19's coffee mug near the top of the rim and pulled it closer to the resident. With the same hand, she stirred the coffee with a</p>	F 441		

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 441	<p>Continued From page 115 plastic spoon.</p> <p>5. On 2/10/14 during the lunch meal observations five staff members were observed assisting residents with meal set up. At 12:27 PM in the Paradise dining room while retrieving resident trays from the food cart, LPN #4 was overhead asking CNA #5, "Are we supposed to be washing our hands?" CNA #5 then whispered something to LPN #4 which the surveyor could not hear. At 12:31 PM the surveyor verified with CNA #5 the exchange and asked her what her answer was to LPN #4's question and she stated it was, "yeah."</p> <p>6. On 2/10/14 at 1:25 pm, CNA #24 was observed to provide peri care for Resident #3. The CNA with gloves on, removed the bed pan with urine in it, and cleaned the resident's buttocks with wipes. With the soiled gloves, the CNA was observed to continue to assist the resident roll side to side, placed a new brief on the resident, and readjust the resident's gown. CNA #24 then took off the soiled gloves and rearranged the resident's pillows. The surveyor asked CNA #24 to state at what point she should have changed her gloves, to which the CNA stated, "Oh yeah, I should have changed my gloves after I did peri care."</p> <p>7. On 2/12/14 at 1:50 pm, LN #6 was observed to provide peri care for Resident #3. LN#6, with gloved hands, assisted the resident to roll onto her side. The resident's bedpan was overflowing with stool and urine. The LN assisted the resident onto her back, opened the drawer of the bedside stand and obtained wipes. The LN assisted the resident onto her side, took out the bedpan, placed it on the floor, and wiped the resident's buttocks. The LN, still wearing the soiled gloves,</p>	F 441			

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

PRINTED: 03/03/2014  
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>C</b> <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 441	<p>Continued From page 116</p> <p>then opened the drawer of the bedside stand and obtained a tube of cream and applied the cream to the resident's buttocks. LN #6 then removed the right glove, with the soiled left glove on, and continued to position the resident's protection pad, returned the wipes to the drawer and then took off the left glove. The resident stated to the LN, "I am still going." When the resident had finished voiding and evacuating, the LN regloved, and wiped the resident's buttocks. With the soiled gloves still on, the LN then got the tube of cream and applied the cream to the resident's buttocks. The LN then took off the right glove and with the left glove still on, placed a new protection pad and positioned the pillow behind the resident's back. Using her left hand with the soiled left glove still on, the LN picked the bedpan off the floor, opened the bathroom door and disposed of the bedpan contents. While in the bathroom the LN stated, "I started nursing way back, when there was only gloves in surgery." When the LN came out of the bathroom and was asked about changing her gloves after providing peri care, no comment was provided. The LN #6 gestured with a smile.</p> <p>8. On 2/12/13 at 4:55 pm, LN#16 was observed to provide an insulin injection to Resident #22. LN#16 administered the injection to the resident's left arm, without wearing gloves. After administering the medication the LN returned to the medication cart, opened drawers and prepared to administer the next resident medications. The LN was asked about not wearing gloves and washing hands after administering an injection with potential for coming in contact with bodily fluid. The LN stated, "I was taught that you don't have to wear gloves to give insulin, but yes, I should have washed my</p>	F 441		

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

PRINTED: 03/03/2014  
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>C</b>  <b>02/14/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - 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 441	Continued From page 117 hands in the room after giving the injection."  On 2/13/14 at 6:15 pm, the Administrator, DON and DDCO were informed of the findings. No additional information was provided.	F 441		

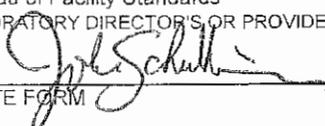
Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001130	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WES	STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	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 state licensure survey at Kindred Canyon West Nursing and Rehab.  Team Members were: Nina Sanderson, LSW BSW Brad Perry, LSW BSW Susan Gollobit RN Jana Duncan RN MSN	C 000		
C 111	02.100,02,f Provide for Sufficient/Qualified Staff  f. The administrator shall be responsible for providing sufficient and qualified staff to carry out all of the basic services offered by the facility, i.e., food services, housekeeping, maintenance, nursing, laundry, etc. This REQUIREMENT is not met as evidenced by: Refer to F353 related to adequate staffing levels to meet residents' needs.	C 111	Refer to the plan of correction for F-353	
C 147	02.100,05,g Prohibited Uses of Chemical Restraints  g. Chemical restraints shall not be 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	C 147	Refer to the plan of correction for F-329	

**RECEIVED**  
APR 21 2014  
**FACILITY STANDARDS**

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 3/17/2014
---	-----------------------------	------------------------

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001130</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/14/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - CANYON WES</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) COMPLETE DATE
C 147	Continued From page 1  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		
C 409	02.120,05,i Required Room Closet Space  i. Closet space in each sleeping room shall be twenty inches by twenty-two inches (20" x 22") per patient/resident. Common closets utilized by two (2) or more patients/residents shall be provided with substantial dividers for separation of each patient's/resident's clothing for prevention of cross contamination. All closets shall be equipped with doors. Freestanding closets shall be deducted from the square footage in the sleeping room. This Rule is not met as evidenced by: Based on observation, resident and staff interview, it was determined that resident room closets on the North Wing, rooms 101-114; on the West Wing, rooms 200-215; and on the South Wing, rooms 302-314, did not meet closet space requirements. Findings included:  On 2/11/13, the facility requested a waiver for resident room closets on the North Wing, rooms 101-114; on the West Wing, rooms 200-215; and on the South Wing, rooms 302-314.  On 2/10/14 at 11:22 AM, resident room 211 was observed with several hangers with clothes on	C 409	<p><b>Resident Specific</b> Residents #3 and #7 will be offered closet space to comply with state requirements for 20" x 22" per patient/resident with installation of new closets.</p> <p><b>Other Residents</b> All other resident room designated closets did not meet the state requirement for size. The center will offer closet space to meet state requirements.</p> <p><b>Center Systems</b> New closets will be purchased by the center in order to meet state requirements. The Social Worker will work with those residents having excessive amounts of items for their room space to encourage them to reduce the amount of belongings in their rooms.</p> <p><b>Date of Compliance</b> April 2, 2014</p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001130	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WES	STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

C 409	<p>Continued From page 2</p> <p>them hanging from the privacy curtain track rod near the window. At 1:59 PM, Resident #7 who occupied the room was interviewed about the clothes hanging off the rod and about closet space. The resident said she did not have enough closet space because, "It's not too big."</p> <p>On 2/10/14 at 1:25 PM, Resident #3 was interviewed regarding her closet space and she stated it, "Could be a little bigger, they are tiny."</p> <p>On 2/11/14 at 10:00 AM during the resident group interview, 10 of 15 residents who attended the interview said they did not have enough closet space. When asked if the facility had offered an alternative to the closet space issue, one resident stated, "They make you get rid of stuff."</p> <p>On 2/11/13 at 12:55 PM, the Administrator indicated the facility would again request a waiver for the closet space requirement. The surveyor informed the Administrator about the resident's concern over the lack of closet space and the Administrator said he was not sure at that time how to fix the issue.</p>	C 409		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of the Infection control Committee (ICC) attendance records, it was determined the facility did not ensure the meetings were attended consistently</p>	C 664	<p><b>Resident Specific</b> No specific residents were disclosed in the summary statement of deficiencies.</p> <p><b>Other Residents</b> An infection control meeting was held on March 28. No other residents were found to be adversely impacted.</p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001130</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/14/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - CANYON WES</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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

C 664	<p>Continued From page 3</p> <p>by the required members. This deficient practice had the potential to cause negative outcomes for all residents, staff and visitors in the facility when ICC members were not involved in the ICC meetings. Findings included:</p> <p>On 2/13/14 at 1:45 pm, the Infection Control LN was asked how often the committee met, and who attended. The LN stated, "We meet monthly and more often if needed." The LN was asked to provide the attendee list of the meetings documenting at least every quarter attendees.</p> <p>On 2/13/14 at 4:05 pm, the Infection Control LN provided the Performance Improvement Meeting attendance signature lists for March 2013, July 2013, and December 2013. When the LN was asked about three missing members in December, the LN stated, "It was the holidays." When asked if all members attended in November, the LN stated, "Housekeeping was missing."</p> <p>The March attendee list did not provide documentation that the meeting was attended by the Medical Director or the Housekeeping representative. The list provided did not have a date on it and the Infection Control LN verified this record was for March.</p> <p>The December attendee list did not provide documentation that the meeting was attended by the Medical Director, DON or Pharmacist.</p> <p>On 2/13/14 at 6:15 pm, the Administrator, DON and DDCO were informed of the findings. No additional information was provided.</p>	C 664	<p><b>Center Systems</b> The center will hold infection control meetings on a quarterly basis, with regular attendance by the required members. Members of the committee were educated during the March meeting regarding the necessity to ensure regular attendance.</p> <p><b>Monitor</b> The ED or designee will ensure that attendance by required members of the committee on a quarterly basis for 2 consecutive meetings. Starting the week of April 2, 2014, documentation will take place on the PI Audit Tool. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring after 2 consecutive meetings, as it deems appropriate.</p> <p><b>Date of Compliance.</b> April 2, 2014</p>	
-------	---	-------	--	--

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001130</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/14/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING &amp; REHAB - CANYON WES</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) COMPLETE DATE
C 674	Continued From page 4	C 674		
C 674	<p>02.151,01 ACTIVITIES PROGRAM</p> <p>151. ACTIVITIES PROGRAM.</p> <p>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 recreation, therapeutic, leisure and religious activities.</p> <p>This Rule is not met as evidenced by: Refer to F248 and F309 related to lack of activities for residents and residents with dementia.</p>	C 674	Refer to the plan of correction for F-248	
C 784	<p>02.200,03,b Resident Needs Identified</p> <p>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:</p> <p>This Rule is not met as evidenced by: Refer to F309 as it pertains to delay of treatment for burns, identification and treatment of fractures, and implementation of Care Plans.</p>	C 784	Refer to the plan of correction for F-309	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001130	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/14/2014
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST	STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 786	Continued From page 5	C 786		
C 786	02.200,03,b,ii Body Alignment, Exercise, Range of Motion  ii. Good body alignment and adequate exercises and range of motion; This Rule is not met as evidenced by: Refer to F317 related to range of motion.	C 786	Refer to the plan of correction for F-317	
C 787	02.200,03,b,iii Fluid/Nutritional Intake  iii. Adequate fluid and nutritional intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Refer to F327 pertaining to hydration.	C 787	Refer to the plan of correction for F-327	
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 related to adequate supervision to prevent falls, side rail safety, and evaluation of residents with abnormal findings.	C 790	Refer to the plan of correction for F-323	
C 811	02.200,04,g,vii Medication Errors Reported to Physician  vii. Medication errors (which shall be reported to the charge nurse and attending physician. This Rule is not met as evidenced by: Refer to F332 related to medication error rate greater than 5%.	C 811	Refer to the plan of correction for F-332	



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 14, 2014

John Schulkins, Administrator  
Kindred Nursing & Rehabilitation-- Canyon West  
2814 South Indiana Avenue  
Caldwell, ID 83605-5925

Provider #: 135051

Dear Mr. Schulkins:

On **February 14, 2014**, a Complaint Investigation survey was conducted at Kindred Nursing & Rehabilitation-- Canyon West. Jana Duncan, R.N., Susan Gollobit, 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 a recertification survey and a second complaint. As part of that process, the records of 22 residents were reviewed.

Both the identified resident, and the resident's roommate, had discharged from the facility prior to the investigation being conducted. The surveyors reviewed the identified resident's record and facility incident reports, including the incident report for the reported fall. Resident, staff, and resident family interviews were conducted. Observations were made in the facility over a four day period.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006033**

**ALLEGATION #1:**

The complainant/reporting party (RP) stated an identified resident fell in the facility. The RP stated the resident's roommate alerted the staff via the call light, but the staff did not respond. The RP stated the resident's roommate had to get dressed, leave the room, and summon staff for assistance.

John Schulkins, Administrator  
March 14, 2014  
Page 2 of 3

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### FINDINGS:

The incident report for the identified fall documented the fall took place on February 10, 2013. A signed statement from the resident's roommate documented the resident attempted to ambulate to the bathroom without first activating the call light. As part of the facility's investigation, the resident's roommate documented s/he observed the resident fall, then simultaneously activated the call light and called out for staff to assist. The resident's roommate documented the staff responded immediately after the call light was activated and s/he began to call for help.

#### ALLEGATION #2:

The RP stated the facility did not place an alarm on an identified resident with a known history of falls.

The survey team reviewed the identified resident's record and conducted staff interviews. The identified resident had a well-documented history of falls prior to her admission to the facility, which was made available to the facility at the time of the resident's admission. While there is no requirement for the facility to place an alarm, and the industry is moving away from alarm use, there is a requirement for the facility to implement a plan to provide adequate supervision to meet the resident's care needs. Even with the facility's knowledge of the resident's fall history, no clear plan was implemented. The deficient practice was cited at F 309.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

#### ALLEGATION #3:

The RP stated an identified resident had residual headaches following a fall, which were unresolved. The RP stated after discharge from the facility, the resident was advised to see a neurologist.

#### FINDINGS:

The identified resident's History and Physical documented a history of falls with headaches and questionable syncope prior to admission to the facility. The resident had been hospitalized on

John Schulkins, Administrator  
March 14, 2014  
Page 3 of 3

several occasions. As part of the work-up to identify the cause of the resident's continued falls, the physician in the hospital, prior to the resident's admission to the facility, had suggested a consultation with a neurologist if other causes could not be ruled out. The medical team working with the resident had identified other possible causes of the resident's falls, had implemented measures to address those causes, and were monitoring the effectiveness of these interventions throughout the resident's stay in the facility. The resident had no more falls documented, the headaches diminished, and the resident successfully discharged back to the community. The plan for aftercare from the facility included if the falls or headaches resumed after discharge, the resident should contact his/her primary care physician to consider a referral to a neurologist.

CONCLUSIONS:

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 slanted.

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

LK/lj



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 12, 2014

John Schulkins, Administrator  
Kindred Nursing & Rehabilitation-- Canyon West  
2814 South Indiana Avenue  
Caldwell, ID 83605-5925

Provider #: 135051

Dear Mr. Schulkins:

On **February 14, 2014**, a Complaint Investigation survey was conducted at Kindred Nursing & Rehabilitation-- Canyon West. Jana Duncan, R.N., Susan Gollobit, R.N., Nina Sanderson, L.S.W., and Bradley Perry, L.S.W., conducted the complaint investigation.

The complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted on February 10-14, 2014.

The following observations were conducted:

- Catheters and Catheter Care was observed for four residents;
- Water and other fluid availability was observed for nine residents; and,
- Water and Ice Pass was observed during the survey.

The following documents were reviewed:

- The entire medical record of the identified resident and four other residents;
- The facility grievance file;
- Resident Council meeting minutes October 2013-January 2014; and,
- Incidents and Accident reports from August 2013-February 2014;

The following interviews were conducted:

FILE COPY

John Schulkins, Administrator  
March 12, 2014  
Page 2 of 5

- Fifteen residents were interviewed at a group interview regarding quality of care issues;
- Four individual residents were interviewed regarding quality of care issues;
- Two resident's family members were interviewed regarding quality of care issues;
- A local Ombudsman was interviewed regarding quality of care issues;
- The Director of Rehabilitation Services was interviewed regarding therapy issues; and,
- The Director of Nursing was interviewed regarding quality of care issues.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006177**

**ALLEGATION #1:**

The complainant stated an identified resident was admitted to the facility on August 20, 2013 and discharged on August 25, 2013. The complainant stated the resident was transported to a local hospital emergency room on August 24, 2013 and the resident was told the area around the catheter was not clean.

**FINDINGS:**

The identified resident was no longer residing in the facility at the time the complaint was investigated.

Based on the identified resident's medical record and staff interview, it was determined catheter care was not provided by the facility as ordered by the physician and the facility was cited at F315 for non-compliance.

**CONCLUSION:**

Substantiated. Federal deficiencies related to the allegation are cited.

**ALLEGATION #2:**

The complainant stated the identified resident's catheter tubing was filled with sediment due to the resident not drinking enough fluids.

**FINDINGS:**

Water and fluid availability was observed for nine residents and water and ice pass were observed during the survey. Catheters and catheter care was observed for four residents.

John Schulkins, Administrator  
March 12, 2014  
Page 3 of 5

The identified resident's closed record was reviewed for fluid intakes and outputs.

The Director of Nursing was interviewed regarding resident's hydration needs.

There was no documented evidence the identified resident was dehydrated. However, two other residents were found to be lacking appropriate hydration while in the facility and the facility was cited for the failure. Please refer to F 327 regarding the failed practice.

#### CONCLUSION:

Substantiated. Federal deficiencies related to the allegation are cited.

#### ALLEGATION #3:

The complainant stated an identified resident had fallen out of bed while in the facility.

#### FINDINGS:

The identified resident's medical record was reviewed for falls and fall prevention. Three other residents were also reviewed for falls.

The Director of Nursing was interviewed regarding falls and fall prevention.

There was no documented evidence in the identified resident's medical record the facility neglected to implement fall prevention measures for the identified resident. However, two other residents were found to have insufficient fall preventions while in the facility and the facility was cited for the failure. Please refer to F 323 regarding the failed practice.

#### CONCLUSION:

Substantiated. Federal deficiencies related to the allegation are cited.

#### ALLEGATION #4:

The complainant stated an identified resident did not receive physical and speech therapy often during the resident's five day stay and the resident lost all function in his left side.

#### FINDINGS:

The rehabilitation records were reviewed for the identified resident and six other residents who

John Schulkins, Administrator  
March 12, 2014  
Page 4 of 5

resided in the facility.

The identified resident's rehabilitation report for the five days the resident was in the facility, documented the resident received 139 minutes of physical therapy, 108 minutes of speech therapy, and 166 minutes of occupational therapy.

The Director of Rehabilitation Services was interviewed regarding the identified resident's progress. She said the resident did not decline in function and had received the appropriate amount of therapy based on each therapist's clinical judgment.

Based on records reviewed and staff interview, it was determined the facility was in compliance with Federal guidelines.

#### CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #5:

The complainant stated an identified resident was admitted to a local hospital with a urinary tract infection (UTI).

#### FINDINGS:

The identified resident's medical record and five other residents were reviewed for UTI's.

The identified resident's medical record did not document any signs or symptoms of a UTI. The identified resident's local emergency room record did not document the resident had a UTI.

The Director of Nursing was interviewed regarding infections and UTI prevention. She said the facility follows UTI infection protocols to help prevent UTI's.

Based on records reviewed and staff interviews, it was determined the facility was in compliance with Federal guidelines.

#### CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the

John Schulkins, Administrator  
March 12, 2014  
Page 5 of 5

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 slanted.

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

LK/lj