



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  
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**CERTIFIED MAIL: 7012 1010 0002 0836 1697**

April 30, 2014

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

Provider #: 135051

Dear Mr. Schulkins:

On **April 16, 2014**, a Complaint Investigation survey was conducted at Kindred Nursing & Rehabilitation - Canyon West by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies 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) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

John A. Schulkins, Administrator  
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After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 13, 2014**. Failure to submit an acceptable PoC by **May 13, 2014**, may result in the imposition of additional civil monetary penalties by **June 2, 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 does 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 (X5).

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

John A. Schulkins, Administrator

April 30, 2014

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when determining your target date for achieving compliance.

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

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

As noted in the Bureau of Facility Standards' letter of March 3, 2014, following the **Recertification, Complaint Investigation and State Licensure** survey of **February 14, 2014**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **August 14, 2014**, if substantial compliance is not achieved by that time.

The findings of noncompliance on **April 16, 2014**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the Centers for Medicare and Medicaid Services on March 6, 2014.

**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 Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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)

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

This request must be received by **May 13, 2014**. If your request for informal dispute resolution is received after **May 13, 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, comments or concerns, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,



Lorene Kayser, Supervisor  
Long Term Care

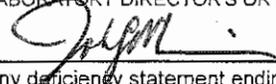
LK/dmj  
Enclosures

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

PRINTED: 04/30/2014  
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 04/16/2014
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	INITIAL COMMENTS  The following deficiencies were cited during a complaint investigation survey of your facility.  The survey team included: Linda Kelly, RN, Team Coordinator, and Rebecca Thomas, RN.  Survey Definitions:  ADL = Activities of Daily Living BOM = Business Office Manager CNA = Certified Nurse Aide DNS/DON = Director Nursing Services/Director of Nursing LPN = Licensed Practical Nurse RN = Registered Nurse SDC = Staff Development Coordinator	F 000		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, it was determined the facility failed to assess a resident who experienced a sudden decline in his health condition, including worsened dyspnea (difficulty breathing). Nurses were notified twice that the resident's condition continued to decline and his breathing had worsened. However, a	F 309	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.	

RECEIVED  
MAY - 6 2014  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE Executive Director (X6) DATE May 6, 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.

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F 309	Continued From page 1 nurse still did not assess the resident. Only after the third notification, and insistence by a CNA, did a nurse assess the resident. By then, the resident was "full of fluid, gurgly" and "foaming at the mouth." No interventions were implemented at that time and the resident died in respiratory distress and discomfort. In addition, the canister for the suction machine on the emergency cart retrieved at the time of the resident's respiratory distress was missing which made the suction equipment inoperable. This was true for 1 of 4 sample residents (#3) and had the potential to affect any resident who may experience a similar situation if nurses failed to respond when notified and for any resident who may need to be suctioned in an emergency situation.  Findings include:  Resident #3 was admitted to the facility in 2011, and readmitted 2/27/14, with multiple diagnoses which included chronic kidney disease, stage 4; sepsis and recurrent urinary tract infections (UTIs); coronary artery disease (CAD); dementia; chronic anemia; and, chronic lower extremity edema. The resident died in the facility on 4/8/14.  A 3/27/14 assessment by a Nurse Practitioner (NP) documented, in part, "SUBJECTIVE: ...increasing anxiety and some agitation lately...appears in no acute distress...easily awakens with verbal stimuli...known to have a significant history of dementia...able to answer questions but...very poor historian...denies chest pain, palpitation, or shortness of breath...pleasant but confused...lungs clear to auscultation...extremities reveal 2+ [plus] edema to the bilateral LE [lower extremities]. ASSESSMENT/PLAN: ...taken off all...diuretics	F 309	<b>F 309 Resident Specific</b> Resident # 1 discharged at the time of the allegation. The licensed charge nurse was counseled regarding timeliness of interaction and communication with staff to best understand "rapid response" conditions. Re-education was provided for respiratory distress and end-of-life care.  <b>Other Residents</b> The Director of Nursing Services (DNS) and Staff Development Coordinator (SDC) completed a respiratory assessment of all residents on 4/15/14. The results showed no other residents currently with end of life or change of condition dyspnea, including current hospice patients.  <b>Center Systems</b> Licensed Nurses and CNA's have been educated by the DNS and/or SDC regarding end-of-life care to include but not limited to o Communication of "rapid response" conditions o Symptoms of respiratory decompensation o Timely and thorough assessment o Pharmacological and non-pharmacological interventions		

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F 309	<p>Continued From page 2</p> <p>as this is related to poor kidney function. Edema is increasing slightly but appears to be stable...I do believe the family is leaning more towards comfort measures at this time as they have recently removed multiple of his medications..."</p> <p>The resident's Care Plan included the following focus areas:</p> <p>* "...altered respiratory status, Difficulty Breathing / Impaired Breathing Pattern..." Interventions were, "Elevate HOB [head of bed] at least 30 degrees per resident preference," initiated 3/10/14, and "O2 [oxygen] at 2 L [liters] per nasal cannula," initiated 3/19/14.</p> <p>* "...ADL Self Care Performance Deficit..." Interventions included, "Mobility/Positioning: ...broda [sic] chair [type of wheelchair] slightly reclined as this is [resident's] comfortable position and is able to self propel..." initiated 1/10/13, "...total care with dressign [sic]," initiated 3/19/14, "Transfer: ...2 staff hoyer [sic] lift," initiated 1/10/13.</p> <p>* "...comfort altered pain..." Interventions included, "Administer medications as ordered..." initiated 10/1/11. "Anticipate need for pain relief and respond immediately to any complaint of pain," initiated 10/1/11. And, "[R]eposition resident in wheelchair to help with pain control," initiated 11/23/12.</p> <p>The resident's Physician's Orders included:</p> <p>* 8/8/08 - Physician Orders for Scope of Treatment (POST) for Do Not Resuscitate (No Code): Allow Natural Death; Patient does not want any heroic or live-saving measures.</p> <p>* 2/28/14 - Norco (opioid pain medication) 5/325 milligrams (mg), 1 tablet (tab) by mouth (PO) 3 times/day and 1 tab every 6 hours as needed (PRN) for pain;</p>	F 309	<p>Education is provided to the licensed nurses regarding rapid response and emergency carts to include but not limited to</p> <ul style="list-style-type: none"> <li>o Rapid response is initiated by the licensed nurse assigned to the resident or licensed nurse identifying an emergency and supported by the RN supervisor.</li> <li>o Rapid response drill with post drill assessment.</li> <li>o The suction machine and canister is secured with break away numbered locks.</li> <li>o The RN supervisor validates daily and documents on the cart inventory check list that the cart is secured and complete.</li> <li>o Emergency carts shall be cleaned and replenished per the cart inventory checklist following use.</li> </ul> <p>The monitoring sheet has been amended to include verification that the emergency cart system contains a suction canister.</p> <p><b>Monitor</b> Monitoring will start May 7, 2014. The DNS and/or designee will review 24 hour report, events/incidents, and CNA communication 5 times each week to validate clinical assessment, intervention, and monitoring meet clinical standards of practice. Reviews will be documented on the Performance Improvement (PI) audit tool for 5 residents per week for 4 weeks, then 4 residents per week for 4 weeks, then 3 residents per week for 4 weeks.</p>	

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F 309	<p>Continued From page 3</p> <ul style="list-style-type: none"> <li>* 3/7/14 - Lasix (diuretic) 40 mg PO 1 time and potassium chloride (supplement) 10 milliequivalents PO 1 time;</li> <li>* 3/13/14 - continuous O2 at 2 L per nasal cannula (NC) for "hypoxia &amp; [and] comfort;"</li> <li>* 3/27/14 - Ativan 0.5 mg, 1 tab PO 2 times/day PRN anxiety/agitation;</li> <li>* 3/28/14 - Roxanol (liquid morphine, an opioid pain medication) 20 milligrams/milliliter (mg/ml), 1/4 to 1 ml every 4 hours PRN pain; and,</li> <li>* 4/4/14 - Tubi grips to both lower and upper extremities "to reduce swelling/edema..."</li> </ul> <p>The resident's March 2014 MAR documentation included:</p> <ul style="list-style-type: none"> <li>* Scheduled Norco was administered 3 times daily and PRN Norco was administered 4 times, with positive results;</li> <li>* Lasix and potassium chloride were both administered 3/7/14;</li> <li>* O2 was administered continuously, except on the evening shift on 3/14 and the night shift on 3/26 (the space for documentation was blank in both places);</li> <li>* Ativan was administered 4 times in 5 day, with positive results; and,</li> <li>* Roxanol was administered 3 times in 4 days, with positive results.</li> </ul> <p>The April 2014 MAR documentation for 4/1 through 4/8/14 included:</p> <ul style="list-style-type: none"> <li>* Scheduled Norco was administered 3 times daily, PRN Norco was not administered;</li> <li>* O2 was administered continuously, except on 4/8 (space for documentation was blank);</li> <li>* Ativan was administered 5 times, with positive results, last dose was 4/7 at 10:00 p.m.; and,</li> <li>* Roxanol was administered 10 times, with positive results, last dose was 4/8 at 12:05 a.m.</li> </ul>	F 309	<p>The DNS completed a rapid response drill Q shift on 4/16/14. The DNS and/or designee will also complete a rapid response drill on each shift during May and June, then once each shift quarterly thereafter. The drills are documented on staff education rosters. Assessments are completed post event/rapid response drill and the results reviewed at monthly licensed nurse staff meetings. Trends and potential for improvement is discussed and taken to the monthly PI committee meeting as indicated.</p> <p>In addition the DNS and/or designee will interview staff to validate:</p> <ul style="list-style-type: none"> <li>o Staff knows their role and understands how to initiate a Rapid Response process.</li> <li>o Staff can identify the location of the emergency cart.</li> <li>o Unlicensed staff knows what to do if the licensed nurse does not respond timely.</li> </ul> <p>5 staff will be interviewed each week for 4 weeks, 4 staff for 4 weeks, then 3 staff for 4 weeks. The review will be documented on the PI audit tool.</p> <p>Also, the SDC and/or designee will monitor emergency carts for necessary equipment 3 times per week for 12 weeks, then one time per week thereafter and co-sign on the emergency cart inventory checklist.</p> <p>Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of monitoring after 12 weeks as it deems appropriate.</p>		

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F 309	<p>Continued From page 4</p> <p>The resident's Progress Notes documentation included:</p> <ul style="list-style-type: none"> <li>* 2/27/14 at 10:02 p.m., Nursing Note (NN) - "Resident re-admitted...appears at baseline...Lung sounds clear bilateral..."</li> <li>* 3/3/14 at 2:03 p.m., NN - "...brief period of yelling...quiet since. Prefers to be up in...chair, continues to have 3+ pitting edema to lower legs."</li> <li>* 3/3/14 at 3:59 p.m., NN - "...tubi grip...to B LE's [bilateral lower extremities] to assist in reducing LE edema..."</li> <li>* 3/7/14 at 9:01 a.m., NN - "...1 time dose of lasix [sic]...and kcl [potassium chloride]...d/t [due to] edema in BLE, cough, r/t [related to] fluid..."</li> <li>* 3/8/14 at 3:02 p.m., NN - "Continues to have periods of yelling out...easily redirected...periods of singing...3+ [plus] edema in lower legs and has had wheezes most of this shift...diminished lung sounds in lower lobes."</li> <li>* 3/10/14 at 2:41 p.m., NN - "Spoke to [relative]...regarding fluid retention, difficulty with breathing, renal function. [Relative] doesn't want Pt [patient] sent to hospital...Would rather have on comfort measures/palliative cares. Will have NP examine Pt on rounds and discuss palliative POC [plan of care]."</li> <li>* 3/12/14 at 6:31 p.m., NN - "...exp[iratory] wheezes no cough..."</li> <li>* 3/14/14 at 5:28 p.m., NN - "...alert with confusion, cheerful and talkative...No SOB [shortness of breath] or cough..."</li> <li>* 3/23/14 at 2:52 p.m., NN - "...increased edema in arms, legs and face...MD [physician] is aware of current status as is [relative]...refuses to lay down..."</li> <li>* 3/27/14 at 1:01 p.m., NN - "...new order for ativan [sic] for increased anxiety/agitation..."</li> <li>* 4/2/14 at 1:05 p.m., Licensed Social Worker -</li> </ul>	F 309	<p><b>Date of Compliance</b> May 7, 2014</p>	

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F 309	<p>Continued From page 5</p> <p>"T/C [telephone call] to [relative]...Reviewed present POST and the only change [relative] wished to make was to indicate no feeding tube...New POST completed...and sent to [relative] with return stamped envelope this day..."</p> <p>* 4/7/14 at 9:35 a.m., NN - "...No signs of respiratory distress."</p> <p>* 4/8/14 at 6:55 a.m., NN - "At [6:20 a.m.] resident yelling out. RN entered room to find resident had pulled O2 NC off, had slid down in bed &amp; was diaphoretic with labored breathing. O2 put back on, &amp; resident repositioned with head elevated. CNA remained in room to complete cares &amp; another CNA summoned to assist with any further repositioning or transfer to chair. LPN went to resident room to give Roxanol, found resident with worsening labored breathing &amp; lg [large] amt [amount] secretions in mouth &amp; throat. Called for RN, RN brought suction machine. Before able to get suction machine tubing &amp; yankaur [sic] [a device used to suction secretions out of the oral cavity, or mouth] connected, resident pupils became fixed, lg amt white secretions frothing from mouth and no further breathing movement. At [6:40 a.m.] no heart tones or pulse detected, pupils fixed &amp; dilated &amp; no breath sounds.</p> <p>On 4/14/14 at about 4:00 p.m., the DNS informed the survey team he and the Administrator had interviewed staff after the resident's death. The DNS provided copies of the interviews which included an RN Supervisor, 1 LPN, and 2 CNAs. The interviews were signed by the DNS and the Administrator; however, they were not signed by the staff. The DNS also provided a copy of a "Summary of Events" by the DNS and the resident's 8/8/08 POST.</p> <p>The staff interviews by the DNS and Administrator</p>	F 309		

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F 309	<p>Continued From page 6 included:</p> <p>* RN Supervisor - "...[RN Supervisor's name]...did not know a lot...comes in at 7:00am...was not here when it occurred."</p> <p>* LN #3 - "...one of the aids came out and asked if [s/he] would go and look at him...he did appear to be in distress...thinks it was approx[imately] 6:30-6:35am...[S/he] went to get the RN supervisor, they came down to his room and he was in distress. [S/he] stated that he was frothing at the mouth and...RN supervisor told someone to go and get the suction machine...happened very quickly and that by 6:40 he has passes away."</p> <p>* CNA #7 - "...[resident's name] was yelling out and...[s/he] went and got the night nurse and they...repositioned him up in bed at approx 6:15...he did seem anxious...night nurse went and got [other CNA's name] and they were going to get him dressed and ready for breakfast...they were getting him dressed...felt that he was still anxious and [other CNA's name] went to go get a nurse. [LPN's name] went and got the RN supervisor...RN supervisor told someone to get the suction machine and so [other CNA's name] went and got the machine...he passed away at approx 6:40am."</p> <p>* CNA #4 - "...[s/he] was asked to go in and and help...get [resident's name] up for breakfast...resident appeared to have some difficulty breathing...entered room around 6:30-6:35...unsure about...time. [CNA]...did not feel comfortable getting him up...went down to get nurse...when the nurse came into the room...she wanted a suction machine...ran down to the dining room and got the crash cart with the suction machine on it."</p> <p>The DNS' "Summary of Events" documented, "It</p>	F 309		

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F 309	<p>Continued From page 7</p> <p>is determined that [resident's name] was seen at 6:20 by a CNA and the RN supervisor. [Resident's name] did respond at that time when he was repositioned...head of bed was elevated when staff entered his room. [Resident's name] was going to be assisted into his wheelchair as two staff members were assisting him. During the process the staff did not feel comfortable with getting him up and one of the aids went and got a nurse to assess him. Upon the assessment he appeared to be in distress and the LPN at the time went and got the RN supervisor and they came down to the room. Upon entering the room [resident's name] was in distress; the RN supervisor at the time instructed someone to go and get a suction machine so they could suction [resident's name]. The crash cart was located and was in route to his room. [Resident's name] passed away at 6:40. Between 6:20 and 6:40 [resident's name] was seen at 6:20 by the RN supervisor, from 6:20 - 6:30 was assisted with two CNA' [sic] from 6:30 - 6:40 was assessed again by an LPN and the RN supervisor. This incident happened very quickly which would indicate it is acute in nature. [Resident's name] was a DNR at the time of the incident.</p> <p>Staff interviews were conducted by the survey team. The interviews revealed the following:</p> <p>* 4/15/14 at 10:43 a.m. - The Business Office Manager (BOM) stated "a few days before the incident on 4/8," the resident was observed in the hall and he was "happy, loud, loud talking." The BOM said on 4/8/14 at "6:15 or 6:20 a.m." s/he heard the resident "holler 'help me' pretty loud." The BOM checked on the resident in his room, "But I couldn't get his attention to find out what he needed." The BOM then went to the "charting</p>	F 309		

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F 309	<p>Continued From page 8</p> <p>room" and informed LN #1 and LN #3 the resident needed a nurse. The BOM stated that LN #1 asked how the resident was laying and the BOM told the nurse the resident was "in bed flat" and "his head wasn't elevated." The BOM said s/he was unsure about the position of the resident's bed and s/he indicated the resident may have slid down in bed.</p> <p>* 4/14/14 at 3:05 p.m. - LN #3 said on 4/8/14 at about 6:15 a.m., during shift report with LN #1, "Someone came down saying [the resident] was yelling" and LN #1 "went down [to the resident's room] right away" and when LN #1 returned they finished report then went to do [the controlled medication] count. LN #3 stated that during count, s/he "pulled Roxanol [took the medication out of the medication cart]" and "I was going to go to his room and take the Roxanol with me." LN #3 stated, "But [LN #1's name] wanted to finish count." LN #3 indicated s/he placed the Roxanol back in the medication cart. LN #3 stated, "In the middle of count," CNA #4 reported that the resident "could not lay down due to the way he was breathing." At that point, about 6:30 a.m., LN #3 "pulled" the Roxanol again and took it to the resident's room. LN #3 said s/he did not give the Roxanol. The LN stated, "He was very full of fluid, gurgly, couldn't cough the phlegm out. He started foaming at the mouth, actual form." LN #3 said CNA #4 went to get the crash cart for the suction machine and just as the CNA got to the resident's room, the resident's "eyes became fixed." LN #3 stated that CNA #4 "seemed upset" when s/he reported that the resident could not be laid down. LN #3 said s/he was not sure if the CNA was upset due to the resident's difficulty breathing or because LN #1 said, "We would finish count first."</p>	F 309		

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F 309	<p>Continued From page 9</p> <p>* 4/14/14 at 3:40 p.m. - LN #2 said s/he saw the resident on 4/6/14 and on that day the resident was "anxious," had a "hard time breathing," and "didn't want to lay down." The LN said the resident frequently pulled off the O2 NC and his lung sounds were "rattily and wet, crackles in his lungs." The LN said s/he did not notice any oral secretion on 4/6/14. LN #2 stated that on 4/8/14 at about 6:15 a.m., while in the charting room, s/he heard CNA #7, and a few minutes later, CNA #4, report to LN #1 and LN #3 that the resident was "struggling to breathe." LN #3 stated that LN #1 told CNA #7, "I'll come down and evaluate him." LN #2 said s/he left the room about that time to care for another resident.</p> <p>* 4/15/14 at 8:40 a.m. - CNA #7 said about 6:00 a.m. on 4/8 the resident had a "hard time breathing" was "anxious" and "struggling a little more than usual." The CNA said LN #1 helped him/her to reposition the resident up in bed, then the nurse went to give report. CNA #4 came to help dress the resident and use the Hoyer (a type of mechanical lift) to transfer the resident from the bed to the wheelchair. CNA #7 said as the CNAs dressed the resident his condition worsened. The CNA indicated the resident struggled to breathe and was restless. The CNA pulled, tugged, and swiped on a surveyor's arms to demonstrate the resident's distress as he pulled/tugged/swiped on the CNA's that morning. CNA #7 stated s/he first reported the resident's condition/breathing had worsened to LN #1 and LN #3 at about 6:15 a.m., while the nurses were in report. CNA #7 indicated that s/he reported, "He sounded worse, breathing was worse, color was worse, clammy, sweaty" and he was "real anxious." The CNA stated LN #1 responded, "We are giving report. We have to do this. We'll be</p>	F 309			

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F 309	<p>Continued From page 10</p> <p>right down." The CNA returned to the resident's room. However, "minutes later" when a nurse did not arrive to assess the resident, CNA #7 left the resident's room again and reported a second time to LN #1 and LN #3, who were now at a medication cart. CNA #7 said s/he told the nurses they "needed to come down and look at him [the resident]." The CNA stated s/he did not recall the nurses' response that time. CNA #7 returned to the resident's room again. However, when a nurse still did not arrive to assess the resident, CNA #4 "ran to grab the nurses" and "got in their faces." "Within a few minutes," LN #3 arrived and asked if the resident was "like this when [LN #1's name] was here" and CNA responded, "Yes." At that point, LN #3 said, "We've got to do something now! Suction!" LN #3 then sent CNA #4 to get LN #1. When LN #1 arrived someone said to get the crash cart. When the crash cart arrived, "Some piece wasn't there [on the suction equipment]." CNA #4 then "ran and got the suction machine from the Paradise dining room." However, by the time the second suction arrived, "It was too late."</p> <p>Note: Twice, the nurses failed to assess the resident after they were notified that the resident's condition had deteriorated and dyspnea had worsened. Only after the third notification did a nurse finally stop what they were doing and go to the resident's room to assess him. However, by that time the resident was in extreme distress. In addition, the first suction set-up was incomplete and therefore non-functional. By the time the second suction set-up was retrieved, the resident had died.</p> <p>* 4/15/14 at 7:28 a.m. - LN #1 stated the resident had been "declining for a long time" and, "We</p>	F 309			

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F 309	Continued From page 11 were working on getting comfort measures in place." The LN said the resident frequently yelled, scooted down in bed, sweated, "looked scared," and took off the O2. LN #1 stated, "We knew the end was coming. We tried to keep him comfortable, gave Roxanol." The LN said that on the morning of 4/8, the resident had pulled off the O2 NC, was confused, had scooted down in bed and was laying flat, was "in distress" and "diaphoretic [sweating]." The LN stated, "About 6:20 a.m." s/he reapplied the resident's O2 NC and assisted CNA #7 to reposition him up in bed. The LN, "Heard rattling but did not see secretions [in the resident's mouth]." LN #1 then sent CNA #4 to assist CNA #7 with the resident's care. LN #1 stated that while s/he and the day shift nurse "counted [controlled medications]", CNA #7 reported, "They couldn't put the resident's head down." LN #1 stated, "I wanted to finish count" and "I couldn't leave an open narc[otic] drawer." As the nurses continued to count, CNA #4 reported, "They could not lay the resident down to get the Hoyer sling under him." The LN indicated the CNA did not say anything about the resident's breathing or secretions. LN #1 stated, however, that the day nurse "wanted to get the suctioning machine." The LN added, "We knew he had a lot of secretions but I didn't want to torture him by suctioning him." LN #1 stated, "I was trying to get things turned over [finish report and narcotic count]." LN #1 stated that the resident was "uncomfortable" and "I expected repositioning to help at 6:20 a.m." When asked if the resident was eligible to have Roxanol at that time, the LN stated, "Yes."  Note: LN #1 did not conduct a thorough assessment of the resident's condition, such as auscultate [listen with a stethoscope] his	F 309			

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F 309	<p>Continued From page 12</p> <p>lungs/breath sounds, check his pulse or respirations/respiratory rate, or obtain the resident's oxygen saturation level when he was "uncomfortable" and "in distress" at 6:20 a.m. Nor did the LN reassess the resident after he was repositioned or after notified that his condition had worsened. In addition, the LN did not provide any other type of intervention, such as Roxanol "for comfort" or Ativan for anxiety. When asked if s/he had received end of life training, LN #1 stated, "Not really. We stop their meds."</p> <p>* 4/15/14 at 9:25 a.m. - CNA #4 said the resident had been "declining, was not speaking as much, not moving as much, wasn't feeding himself." The CNA said during the resident's last "1 to 2 days" there was a "little more swelling" in his arms and he had to sit up because he was "filling with fluid, slowly drowning." The CNA stated that on 4/8/14 at about 6:15 a.m., "You could hear him gurgling" but he was "still speaking." Then, as CNA #4 and CNA #7 tried to get the resident dressed, "He was gasping, gurgling. He was getting worse." CNA #4 stated s/he reported to LN #1 and LN #3, who were "counting pills," that the resident needed to be suctioned "because he had water in his lungs." The CNA said LN #1 responded, "We can't suction without a doctor's order" and "don't lay him down." CNA #4 stated s/he asked, "How are we suppose to get the Hoyer sling under him if we can't lay him down." CNA #4 stated s/he "insisted" the nurses check the resident and told them the resident was "going to drown." The CNA said it was "5 minutes at the most" from the time s/he talked to the nurses before LN #3 checked the resident. CNA #4 stated when LN #3 saw the resident's condition, the LN instructed CNA #4 to get LN #1. CNA #4 said LN #1 was with another resident on another hall and it took "3 or 4</p>	F 309			

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F 309	<p>Continued From page 13</p> <p>minutes" for LN #1 to get the Resident #3's room. CNA #4 went to the resident's soon after that and someone said to "get the crash cart." CNA #4 "ran" and got the crash cart and took it to the resident's room. CNA #4 stated, however, the suction canister was missing and someone said to get a suction machine from one of the dining rooms. CNA #4 said s/he "ran" and got the suction machine then "ran" back to the resident's room but by that time the resident had died.</p> <p>* 4/15/14 at 9:05 a.m. - CNA #5 said s/he had seen the resident on 4/7/14 and the resident "seemed okay" and "there was nothing abnormal and no discomfort or trouble breathing." The CNA said on 4/8/14 at about 6:30 a.m., "The resident was sitting up in bed. There was a bunch of phlegm in his mouth and he was trying to talk but he couldn't talk. He was very alert and aware. He was in distress. He was wide eyed and trying to talk." The CNA stated, "It was frantic" and that several staff were in the resident's room and hallway and staff were running up and down the halls.</p> <p>On 4/15/15 at 11:05 a.m., the DNS was asked about the events surrounding Resident #3's death. The DNS stated: On 4/8/14 at 6:15 a.m., the resident was "hollering" which was "not abnormal." A staff member checked on the resident then the night nurse "went down" and got an aide to help get the resident up for breakfast. "Somewhere between, the resident took a turn for the worse." The on-coming day nurse "went in" and she called for the night nurse "because he was foaming." "The CNAs felt like they weren't heard immediately." Only one CNA talked to the nurses "that I am aware of." When asked why staff were interviewed, the DNS stated, "Because</p>	F 309			

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F 309	<p>Continued From page 14</p> <p>he was beloved and due to his sudden death. We had prepared the family but it was sudden." When asked if night nurse had been interviewed, the DNA stated, "I talked to [night nurse's name] but I didn't write it down." The DNS stated the "night nurse" was the RN Supervisor on duty on the morning of 4/8/14.</p> <p>On 4/15/14 at 11:20 a.m., the DNS and both surveyors observed the crash cart, which was located on Hall 1. The DNS uncovered the suction machine which was on top of the cart. The DNS stated, "It's the night nurses' responsibility to check the crash cart." When asked if the suction set-up on the crash cart was complete on 4/8/14, the DNS stated, "It was missing the canister." Upon request, the DNS provided a copy of the emergency cart supply checklist.</p> <p>The emergency cart supply checklist included a section to check off items on the top of the cart which included, "Suction Machine w/ tubing" and "Yankauer Suction." (Note: Suction canister was not listed on the checklist.) A check mark was noted for the suction machine and the Yankauer every day 4/1 through 4/14/14, including on 4/8/14. The checklist also included a section for "Initials of Nurse" for each day of the month.</p> <p>Right after the aforementioned crash cart suction set-up observation, the DNS was asked who initialed the emergency cart supply checklist on 4/7 and 4/8/14. The DNS said he would find out and get back with the survey team.</p> <p>At about 11:30 a.m., the DNS stated the nurses had had been consistently checking the "crash [synonymous with emergency] cart and the Staff</p>	F 309		

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F 309	<p>Continued From page 15</p> <p>Development Coordinator (SDC) had taken over the task. He stated the SDC initialed the emergency cart supply checklist on 4/7 and 4/8/14.</p> <p>On 4/15/14 at 11:35 a.m., the SDC was interviewed. When asked about the emergency cart supply checklist, the SDC confirmed s/he had initialed it on 4/7 and 4/8/14. When asked if s/he had ever used suction equipment during his/her nursing career, the SDC stated, "Yes." The SDC stated s/he knew what was needed for a complete suction set-up. The SDC stated the suction set-up on the emergency cart was complete on 4/7 and, "I had to redo it on the 8th after the resident passed." When asked if any other residents required suctioning, the SDC indicated no. When asked why the suction canister was missing on the morning of 4/8/14, the SDC indicated s/he did not know. The SDC stated that a suction set-up is located in both dining rooms and extra suction machines and equipment was in a centrally located closet.</p> <p>On 4/15/14 at 1:50 p.m., a follow-up interview with the DNS was conducted by the survey team. When asked what nurses should do when informed of a sudden decline in a resident's condition, the DNS stated, "They should go and do an assessment as quick as possible." When asked if it was during report, the DNS stated, "They should stop what they are doing and go assess the resident." When asked if it was during narcotic count, the DNS stated, "They should mark their spot and go down quickly." When asked about the missing suction canister on the morning of 4/8/14, the DNS stated, "I did not do anything to investigate." When asked if any other resident(s) required suctioning, the DNS said he</p>	F 309			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 16</p> <p>did not know and, "Certainly they can get a supply from the O2 room." The DNS said extra suction machines and equipment was stored in there. When asked if staff had received training on end of life care, the DNS stated, "Not specifically on end of life care." The DNS said there were "no specific comfort care orders" for Resident #3 but the resident "was on Roxanol for pain/comfort."</p> <p>Resident #3 had increased edema after all diuretics were discontinued because of advanced kidney failure. His health condition was gradually declining. The resident's code status was DNR and the family voiced their wishes for no hospitalizations. Oxygen was ordered in mid March 2014 for "hypoxia and comfort." PRN Ativan and oral morphine solution (Roxanol) were ordered in late March 2014 for anxiety/agitation and pain control, respectively, with good results when they were used. On 4/8/14 at about 6:15 - 6:20 a.m., the resident was more anxious than usual and a nurse helped reposition him but failed to conduct a thorough assessment or administer Ativan for the anxiety or Roxanol for comfort despite "labored breathing." The nurse left the resident and 2 CNAs to attend to the resident whose condition deteriorated rapidly over the next approximately 10 minutes. During this time the CNAs reported the resident's deteriorating condition and worsening respiratory status to nurses 3 times and only after the third notification did a nurse, the on-coming day nurse, stop what s/he was doing and go to the resident's room to assess him. The on-coming day nurse took Roxanol to the resident's room but did not administer the fast acting medication which could have eased the resident's respiratory distress and provided some comfort in the resident's last moments of life. The emergency suction</p>	F 309		

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

PRINTED: 04/30/2014  
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 04/16/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHAB - CANYON WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
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F 309	Continued From page 17 equipment was inoperable without a canister and it took additional time to obtain a complete suction set-up with which to clear the resident's mouth secretions.	F 309		

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>04/16/2014</b>
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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>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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C 000	16.03.02 INITIAL COMMENTS  The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiency was cited during a complaint investigation of your facility.  The survey team included: Linda Kelly, RN, Team Coordinator, and Rebecca Thomas, RN.	C 000		
C 784	02.200,03,b Resident Needs Identified  b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Refer to F 309 as it related to residents highest practicable physical, mental, and psychosocial well being.	C 784	See plan of correction for F-309.	

**RECEIVED**  
**MAY - 6 2014**  
**FACILITY STANDARDS**

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Executive Director</b>	(X6) DATE <b>May 6, 2014</b>
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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

May 21, 2014

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

Provider #: 135051

Dear Mr. Schulkins:

On **April 16, 2014**, a Complaint Investigation survey was conducted at Kindred Nursing & Rehabilitation - Canyon West. Linda Kelly, R.N. and Becky Thomas, R.N. conducted the complaint investigation. This complaint was investigated on April 14, 2014 through April 16, 2014.

The following documentation was reviewed:

- Clinical records for an identified resident;
- Census Report for April 14, 2014;
- Emergency Cart Supply Checklist for April 2014;
- Incident/Accident Reports and grievances for February, March and April 2014;
- Licensed Nurses (LN) and Certified Nurse Aides (CNA) scheduled for April 5 through 19, 2014;
- Summary of Events statement by the Director of Nursing Services (DNS) dated April 8, 2014;
- Interviews of four staff conducted by the Administrator and DNS on April 8, 2014;
- Transfer/discharge summary for February, March and April 2014; and,
- Policies and procedures regarding End of Life Care, Pain Management and Oxygen Therapy.

The Administrator, DNS, Staff Development Coordinator, three LNs, four CNAs and a Business Office staff member were interviewed.

The suction equipment on the emergency cart and in two dining rooms was observed during the investigation.

The complaint allegations, findings and conclusions are as follows:

John A. Schulkins, Administrator  
May 21, 2014  
Page 2 of 2

**Complaint #ID00006443**

ALLEGATION #1:

The complainant stated an identified resident was choking on his own saliva around 6:00 a.m. When two CNAs alerted the nurse(s) of the resident's distress, the nurse said s/he "was busy with report" and did not go to the resident. A nurse eventually did go to the resident's room. That nurse called for a second nurse; they had a discussion for several minutes about what to do. Finally, one of the nurses asked another staff member to go get the suction machine. By the time the staff member got back with the suction machine, the resident had died.

FINDINGS:

Per review of the identified resident's record and staff interviews on April 8, 2014, the resident was "in distress" shortly after 6:00 a.m. and died at approximately 6:40 a.m. There was no documented evidence that a thorough assessment was done during that time, and the resident died with a large amount of secretions in his/her mouth and throat. In addition, the emergency suction equipment was incomplete, and therefore inoperable, when it was needed.

The facility was cited at F309 at the potential for harm level for this failed practice.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

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, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care 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,



DAVID SCOTT, R.N., Supervisor  
Long Term Care

LT/dmj