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



June 24, 2015

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

Provider #: 135051

Dear Mr. Schulkins:

On **June 4, 2015**, a 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. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE**: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 7, 2015**. Failure to submit an acceptable PoC by **July 7, 2015**, may result in the imposition of civil monetary penalties by **July 27, 2015**.

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

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

  If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.
- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **July 9, 2015 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **July 9, 2015**. A change in the seriousness of the deficiencies on **July 9, 2015**, may result in a change in

the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 9, 2015** includes the following:

Denial of payment for new admissions effective **September 4, 2015.** [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 4, 2015**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **June 4, 2015** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **July 7, 2015**. If your request for informal dispute resolution is received after **July 7, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

D. L. Scott

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

DS/dmj
Enclosures

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135051 | A. BUILDING _____ B. WING _____ | 06/04/2015 |

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

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| F 000 | INITIAL COMMENTS<br><br>The following deficiencies were cited during the annual federal recertification and complaint survey of your facility.<br><br>The surveyors conducting the survey were:<br>Linda Hukill-Neil, RN, Team Coordinator<br>Rebecca Thomas, RN<br>Amy Barkley, RN, BSN<br>Becka Watkins, RN, BA<br><br>The survey team entered the facility on June 1, 2015 and exited on June 4, 2015.<br><br>Survey Definitions:<br>ADL = Activities of Daily Living<br>BID = Twice per day<br>BIMS = Brief Interview for Mental Status<br>cm = Centimeters<br>CNA = Certified Nurse Aide<br>DDOC = District Director of Clinical Operations<br>DNS = Director of Nursing Services<br>DX = Diagnosis<br>g = gram<br>LN = Licensed Nurse<br>MAR = Medication Administration Record<br>MDS = Minimum Data Set assessment<br>MG = Milligrams<br>ML = Milliliters<br>PRN = As Needed<br>PO = by mouth<br>Q = every<br>TAR = Treatment Administration Record<br>W/C = Wheelchair | F 000 | RECEIVED<br>JUL - 7 2015<br>DIV OF LIC & CERT | |
| F 253<br>SS=E | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and | 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 | |

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

John Chilton | Executive Director | 7/1/2015

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 253 | Continued From page 1<br>maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, it was determined the facility failed to maintain an environment in good repair as evidenced by peeling wallpaper and missing dry wall, paint, wallpaper, and baseboards throughout the facility and in 11 resident rooms. This had the potential to adversely affect a sense of comfort for all residents living in the facility. Findings include:<br><br>During survey, from 6/1/15 to 6/5/15, the following was observed:<br>- Approximately 72 inches of missing wallpaper above the hallway handrail between the dish room and the Paradise dining room.<br>-Room 207 - Missing drywall above the baseboards on the right side of the room when facing the window.<br>- Room 208 - Missing wallpaper on the right side of the room when facing toward the window, which was more than 24 inches in length and a wallpaper rip approximately 6 inches in length.<br>- Room 203 - Two gaps of missing dry wall the size of a quarter above the baseboards on the right side of the room when facing toward the window.<br>-Room 302 - Missing baseboard on the right side of the room when facing the window, which had tattered and missing dry wall.<br>- Room 305 - More than 33 spots of white spackle 1-2 inches in size over the walls in various spots.<br>- Dirty utility room door, between rooms 307 and 309, with deep marks where the outer layer of the | F 253 | 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.<br><br>**F 253**<br>**Resident Specific**<br>Common areas and resident rooms 203, 207, 208, 302, 305, 306, 307,309, 311, and 313 have been repaired to include wall patches, paint, repaired/removed wallpaper, doors, and baseboards.<br><br>The call light touch pad in room 314 has been replaced.<br><br>**Other Residents**<br>The Executive Director (ED) and Maintenance Supervisor (MS) performed an inspection of the remainder of the building to identify homelike environmental repairs needed to include but not limited to, wall patches, wallpaper, paint, doors, baseboards, and call light pads. Areas noted as needing repaired have subsequently been repaired.<br><br>**Systemic Changes**<br>The ED and/or Staff Development Coordinator (SDC) has re-educated staff and the MS regarding observation of resident room environment, equipment failure monitoring, completion of work orders, and timeliness of repairs. The MS maintains the center with a homelike | |

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| F 253 | Continued From page 2<br>door ' s surface had been scraped off.<br>- Room 311 - More than 5 spots of white spackle on the bathroom wall near the toilet and dark yellow stains on the floor at the base of the toilet.<br>- Room 313 - 5 areas of missing paint above the bed and below the wall light.<br>- Room 306 - Peeling wallpaper below the wall light and above the bed and more than 18 spots of white spackle on the walls 1-2 inches in size in various areas.<br>- 300 Hall community room - Missing paint in various locations, and peeling wallpaper in the corner of the right wall just after the entry.<br>-Room 314 A - Missing rubber on a resident call light touch pad, which exposed the inner hardware.<br>- Hallway door across the hall from Room 214 - Cracked and peeling wood.<br>- Across from the main entrance and to the left of the activities calendar - 5 spots, 1-2 inches in size, of white spackle.<br><br>On 6/3/15 at 2:45 PM, a tour of the facility was performed with the Maintenance Supervisor (MS). When asked about the peeling wallpaper, as well as the missing dry wall, paint, wallpaper, and baseboards throughout the facility, the MS stated he and the facility were aware of the concerns and had plans to fix them in the near future.<br><br>On 6/4/15, at 6:00 PM, the Administrator, DNS and the DDCO, were informed of the findings. There was no additional information provided by the facility. | F 253 | environment. 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, paint, wallpaper, baseboards, doors, and call lights.<br><br>Education is provided to the MS regarding use of the room painting schedule. Preventative maintenance monitoring sheets have been amended to include verification that drywall, wallpaper is in good condition, that patches are painted, doors are clean and without splintering wood, and that call light pads are in proper condition.<br><br>**Monitor**<br>The MS will review the maintenance logs request Monday through Friday to validate that no additional paint, wall, or door repair is needed. In addition, room rounds will be performed for 5 rooms per week for 4 weeks, then 4 rooms per week for 4 weeks, then 3 rooms per week for 4 weeks. Starting July 9, 2015, documentation will take place on the Performance Improvement (PI) Audit Tool.<br><br>The ED is assigned oversight and will perform rounds weekly, review the painting schedule monthly, and validate sustained compliance. 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 12 weeks, as it deems appropriate.<br><br>**Date of Compliance**<br>July 9, 2015 | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged | F 280 | | |

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| F 280 | Continued From page 3<br>incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, it was determined the facility failed to update and/or revise residents' care plans after there were changes in the residents' status. This was true for 3 of 12 sample residents (#s 2, 3, & 8). This failure created the potentional for harm when staff did not have current care directives for Resident #2's RNA ambulation and daily foot care; Resident #3's catheter care, hand edema glove, and post operative care; and Resident #8's ambulation, bed mobility, and weight bearing status. Findings included:<br><br>1. Resident #2 was admitted on 8/16/12, and readmitted to the facility on 7/5/13, with multiple diagnoses including End Stage Renal Disease, | F 280 | This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation - Canyon West does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the 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.<br><br>**F280**<br>**Resident Specific**<br>Resident #2's care plan has been updated to reflect current condition. Resident #3 and #8 have been discharged from the center.<br><br>**Other Residents**<br>The Interdisciplinary (ID) team reviewed other resident care plans and adjusted care plan accuracy focused on Restorative Nursing Assistant (RNA) programming, catheter care and management, mobility status, post operative cares, and edema management.<br><br>**Systemic Changes**<br>Resident care plans are established upon admission, reviewed quarterly, and updated periodically with resident changes. The SDC and/or Director of Nursing Services (DNS) has re-educated licensed nurse staff regarding care plan updates to include but not limited to, RNA programming, catheter care and management, mobility status, post operative cares, edema management, and foot care. Daily validation of care plan | |

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| F 280 | Continued From page 4<br>chronic ischemic heart disease, diabetes, and dementia.<br><br>The resident's quarterly MDS assessment, dated 3/2/15, documented:<br>*BIMS of 14 - intact cognition;<br>*Extensive assist with 1 staff for dressing, personal hygiene, and ambulation in the room;<br>*Ambulation outside of the room did not occur;<br>*Functional limitation on one side of the lower extremities; and,<br>*Frequently incontinent of bladder and occasionally incontinent of bowel.<br><br>Resident #2's current Care Plan documented:<br>- Focus: Diabetes Mellitus<br>Interventions: "Wash feet daily with mild soap and water. Dry thoroughly. May use a light dusting powder or lotion. Do not apply lotion or powder between the toes." Date Initiated: 5/18/14.<br>-Focus: Maintenance restorative nursing program<br>Interventions: "RNA to ambulate pt [patient] with FWW [front wheel walker] 50-100' six to seven days a week for at least 15 minutes for strengthening." Date Revised: 6/9/14 - "Pt will attend group therapeutic exercises for AROM [active range of motion] as tolerated with a goal of 6-7 times/week for a minimum of 15 minutes."<br><br>The resident's Restorative Aide Flow Sheet Record documented:<br>Group therapy exercises 6-7 times a week for AROM was discontinued on 1/29/15.<br>Ambulation with a FWW for 50-100' was discontinued on 1/29/15.<br><br>The resident's March, April, May & June 2015 CNA Nursing Order Flow Sheet Records had no documentation to reflect the resident's feet were | F 280 | updates will occur by clinical management during the morning clinical meeting for residents with changes. Ongoing review will occur by the ID team with quarterly care conferences.<br><br>**Monitor**<br>The DNS and/or designee will audit two care plans per week for 12 weeks to validate accuracy and timely revisions. Starting July 9, 2015, 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 12 weeks, as it deems appropriate.<br><br>**Date of Compliance**<br>July 9, 2015 | |

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| F 280 | Continued From page 5<br>washed daily with mild soap and water.<br><br>On 6/2/15 at 7:45 AM, Resident #2 was observed as he propelled himself in a wheelchair from the dining room back to his room. The resident was interviewed about his ambulation ability. The resident stated he used to be able to bear weight, but he is not steady on his feet and does not ambulate in the halls. Resident #2 said he still independently transfers himself from his W/C to his bed and from his W/C to the toilet. The resident stated he had fallen in the past and so he had an alarm on the bathroom door to alert staff he had entered the bathroom and needed staff assist him out.<br><br>On 6/4/15 at 4:35 PM, the DNS was interviewed with the DDCO present, in regards to the interventions documented on the Care Plan. The DNS acknowledged the resident had not been ambulated with RNA nor attended group therapy 6-7 times a week since 1/29/15. The DNS said washing the resident's feet daily was a nursing intervention, but no longer needed to be done. The DNS stated, "It should have been taken off the Care Plan."<br><br>2. Resident #3 was readmitted to the facility on 3/9/15 with multiple diagnoses including chronic kidney disease, dementia, hypertrophic prostate with ureter obstruction, recurrent UTIs with hospitalization for sepsis, and a suprapubic catheter.<br><br>The 3/16/15 admission MDS assessment documented:<br>*BIMS of 11 - Cognition moderately impaired;<br>*Total support with 2 staff assist for transfers;<br>*Extensive assist with 1 staff for dressing, | F 280 | | |

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| F 280 | Continued From page 6<br>toileting, and personal hygiene; and,<br>*Indwelling catheter.<br><br>The resident's 4/10/15 Physician's Orders and June 2015 recapitulation Physician's Orders documented:<br>4/10/15: "Pt [patient] is D/C'd [discontinued] off skilled OT [occupational therapy] secondary to reaching a baseline..."<br>4/27/15: "Suprapubic catheter 16FR [French] 30CC [cubic centimeters] balloon change every month on the 27th day of the month and as needed."<br><br>Resident #3's current Care Plan documented:<br>- Focus: Impairment to skin integrity<br>Interventions: "Post op cholecystectomy and requires post op surgical cares to surgical site." Date Initiated: 3/9/15<br>- Focus: Indwelling suprapubic catheter<br>Interventions: "Catheter: last changed: 1/12/15 Change catheter every 4 weeks." Date Initiated: 1/14/15<br>"Catheter...has size 24FR with 5CC balloon..." Date Initiated: 1/14/15<br>- Focus: High fall risk<br>Interventions: "Pt to have R [right] hand edema glove during days and off at nights please keep arm on pillow elevated when in bed." Date Initiated: 1/13/15<br><br>The resident's MAR/TAR documented:<br>*The resident's catheter was changed on 5/5/15 and 5/15/15 due to occlusion. The catheter was changed again on 5/29/15 and 6/2/15.<br>Note: There was no documentation on the MAR/TAR for the size of the catheter and no documentation to reflect the right handed edema glove was provided during the days and removed | F 280 | | |

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| F 280 | Continued From page 7<br>at nights.<br><br>On 6/1/15 at 9:30 AM, 6/2/15 at 9:20 AM, and 6/3/15 at 9:40 AM, the resident was observed to have catheter tubing and a foley in a privacy bag.<br><br>On 6/4/15 at 9:20 AM, the DNS was interviewed with the DDCO in attendance in regards to the catheter information, post op care after a cholecystectomy performed on 3/3/15, and the edema glove. The DNS acknowledged the Care Plan needed to be updated/revised. The DNS stated the cholecystectomy post op care, the last date the catheter was changed, the size of the catheter and balloon size, the hand edema glove, and arm elevation all should have been removed from the resident's Care Plan as the post op care, arm elevation and edema glove interventions were no longer in effect. The catheter size had been updated on 4/27/15 and the catheter change was physician-ordered to be changed every 4 weeks.<br><br>3. Resident #8 was readmitted to the facility on 1/13/15 for aftercare healing of a traumatic upper leg fracture and rehabilitation.<br><br>The 4/17/15 quarterly MDS assessment documented:<br>*BIMS of 15 - Cognition intact;<br>*Supervision with setup help only for bed mobility, transfers, walking in and out of room, and ambulation on the unit; and,<br>*Limited assist with 1 person for ambulation off the unit.<br><br>The resident's Physician's Progress Notes documented:<br>4/1/15 - "ROM [range of motion] knee | F 280 | | |

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| | 135051 | A. BUILDING _____ B. WING _____ | 06/04/2015 |

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

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| F 280 | Continued From page 8<br>0-10...xrays show alignment stable...Plan: 40% WB [weight bearing] Begin PT f/u [follow up] 6 wks [weeks]"<br>6/3/15 - "Pt reports doing well and wanting to go home...doing most of her ADL by herself..."<br><br>The resident's 5/14/15 Physician's Orders documented:<br>"PT clarification order: PT to eval [evaluate] & treat 5 X [times] week X 4 weeks to progress WBAT [weight bearing as tolerated]."<br><br>Resident #8's current Care Plan documented:<br>- Focus: Limited physical mobility related to a fractured femur<br>Interventions: "Ambulation: [Resident's name] requires two person assistance with ambulation."<br>Date initiated: 1/14/15<br>"Bed Mobility: Resident requires one person assistance with bed mobility."<br>- Focus: Moderate risk for falls<br>Interventions: "[Resident's name] is non weight bearing to right lower extremity."<br><br>On 6/1/15 at 2:00 PM, Resident #8 was observed in her room with a brace on her right leg. The resident used her front wheel walker to ambulate to the bathroom independently. The resident said she was independent in her room, but used her W/C for longer distances or had a staff member walk by her.<br><br>On 6/3/15 at 8:35 AM, the physical therapist on duty (PT) was interviewed regarding the resident's ambulation abilities. The PT stated the resident was independent in her room and was stand-by assist on the rehabilitation hall, and was planned to return home very soon. | F 280 | | |

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| F 280 | Continued From page 9<br>On 6/4/15 at 8:30 AM, the DNS, with the DDCO present, was interviewed about Resident #8's Care Plan. The DNS acknowledged, the resident's condition had improved and she was able to bear weight, ambulate with stand-by assist, and was independent in her room. The DNS said the Care Plan needed to be updated to reflect her current ADL abilities.<br><br>On 6/4/15 at 5:55 PM, the Administrator, DDCO, and the DNS were informed of the Care Plan concerns. The facility did not provide any additional information to alleviate the issues. | F 280 | | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, it was determined the facility failed to ensure professional standards of quality were met by not developing a resident's initial plan of care within 24 hours of admission. This was true for 1 of 14 (#13) sample residents. This failure created the potential for more than minimal harm when a Care Plan to address Resident #13's immediate needs was not completed until 3 days after admission. Findings included:<br><br>Resident #13 was admitted to the facility on 1/23/15 with multiple diagnoses including urinary tract infection (UTI), encephalopathy due to UTI, history of cerebrovascular accident (CVA)with left sided hemiparesis, muscle weakness, | F 281 | This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation - Canyon West does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.<br><br>**F281**<br>**Resident Specific**<br>Resident # 13 has discharged from the center.<br><br>**Other Residents**<br>Clinical leadership reviewed other new admission residents to validate and/or establish a plan of care. Current resident plans of care are established. | |

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|---|---|---|---|---|
| F 281 | Continued From page 10<br>rehabilitation, and dementia. The resident was discharged from the facility on 2/5/15.<br><br>The facility's Policies and Procedures for Care Plans, dated 1/7/12, documented:<br>"...An initial plan of care is developed within 24 hours of admission to address the immediate needs of the patient until a comprehensive care plan can be developed..."<br><br>The resident's hospital progress note, dated 1/22/15, documented the assessment (A)/plan (P):<br>1. UTI - "A: due to e coli, P: Course of abx [antibiotic] stopped, better, repeated ua [urinalysis] was negative";<br>2. Encephalopathy - "A: due to UTI, P: near baseline, continue with supportive tx [treatment]";<br>3. Debility - "A: secondary to medical illness and left side cva, P: continue to follow clinically";<br>4. Protein calorie malnutrition - "A: mild, P: dietician to help";<br>5. CVA - "A: recent with left hemiparesis, P: pt/ot";<br>6. CKD (chronic kidney disease) stage 3 - "A: follow closely, P: creat [creatinine] is normal";<br>7. DM (diabetes mellitus) - "A: type II..., P: follow closely";<br>8. Volume overload - "A: possibly due to diatolic [sic. diastolic] chf [congestive heart failure], P: continue to follow clinically. better, stopped lasix for now";<br>9. Hypomagnesemia - "A: moderate, P: better";<br>10. Hypokalemia - "A: mild, P: better"; and,<br>11. Acute renal failure - "A: possibly from over diuresis. If renal functional does not improve will need to stop Lisinopril, P: 1/20 after given 1 L [liter] of ns [normal saline], renal function has improved, will monitor" | F 281 | **Systemic Changes**<br>The SDC and/or DNS has re-educated nursing staff regarding establishment of an initial care plan within 24 hours of admission. The admission check list includes minimal areas to be established on the plan of care with a check off systems for items completed to communicate items still needing completion for transition between shifts. Clinical leadersbip will review for implementation at the clinical morning meeting. The Minimum Data Set (MDS) and/or Case Management nurse will validate timely initiation of care plans.<br><br>**Monitor**<br>The DNS and/or designee will audit two new admission records weekly for 12 weeks to validate initial care plans are established timely. Starting the July 9, 2015, 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 12 weeks, as it deems appropriate.<br><br>**Date of Compliance**<br>July 9, 2015 | |

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|---|---|---|---|---|
| F 281 | Continued From page 11<br>Resident #13's Admission Orders, dated 1/23/15, documented the resident's diagnoses, medications, allergies, the inability of making her own decisions, a regular diet, regular texture, regular liquids, and Physical (PT), Occupational (OT), Speech therapy evaluation and treatments.<br><br>Resident #13's progress notes documented:<br>1/23/15 - "Admission Patient Nursing Evaluation Part 1 completed. [Resident's name] admitted via [facility's name] transport...via W/C...24 Hour Patient Nursing Evaluation completed...cooperative with cares...no acute distress...tol [tolerates] po [by mouth] fluids...Left sided residual from CVA. Prevalon boots on splint removed from lt [left] hand and wrist per res [resident] request..."<br>1/24/15 - "...Res complaint free in no acute distress. Res orients to room and surroundings. Res is legally blind and is using a soft touch call light...Res here for PT and OT, and will be evaluated this weekend..."<br>1/25/15 - "...alert, able to make needs known...Hoyer lift for all transfers with X [times] 2 max assist, X 1 max assist for ADLs. Continent of Bowel and Bladder with use of bed pan while in bed. Does call out frequently, easily re-directed. Cooperative and pleasant with cares..."<br><br>The resident's initial Care Plan, with the first focuses, goals, and interventions, was initiated on 1/26/15, which was 3 days after her admission to the facility.<br><br>On 6/4/15 at 3:22 PM, the DNS was interviewed in regards to care directives for new residents. The DNS said the development of a temporary Care Plan needed to be completed within the first 24 hours of admission to the facility. The DNS | F 281 | | |

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| F 281 | Continued From page 12<br>acknowledged Resident #13 should have had a temporary Care Plan and did not.<br><br>On 6/4/15 at 5:55 PM, the Administrator, DDCO, and DNS were informed of the issue. There was no additional information provided to alleviate the concerns. | F 281 | | |
| F 309 SS=E | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and record review, it was determined the facility failed to provide the necessary care and services to meet the needs for 4 of 14 sampled residents (#2, #7, #12, and #14). The facility failed to:<br>* Consistently check Resident #2's blood sugars (BG);<br>* Administer Lantus Insulin without knowledge of Resident #2's BG;<br>* Administer Resident #2's renal disease medication as ordered;<br>* Monitor and provide appropriate dialysis care for Resident #2; and<br>* Monitor Resident #2's blood pressure and heart rate prior to administering cardiac medications;<br>These deficient practices placed Resident #2 at risk for hypoglycemia and/or hyperglycemia, | 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.<br><br>**F309**<br>**Specific Residents**<br>Resident #2, #7, and #12 medical records were not adjusted as legally no retroactive changes can be made. Resident #7 Apidra order was clarified by the physician. DNS observation validates that current licensed nurse flow sheets are complete with orders initialed and values noted when carried out. Resident #14 has discharged from the center.<br><br>**Other Residents**<br>DNS review shows other resident records had similar deficient practices with incomplete licensed nurse flow sheets where nursing initials and/or values were not present for all orders carried out. No | |

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| F 309 | Continued From page 13<br>complications with dialysis treatment, and heart failure.<br>Additionally, the facility failed to:<br>* Implement ordered interventions for constipation, which put Resident #7 at risk for bowel obstruction, hospitalization and or surgery;<br>* Clarify an incomplete order for Apidra Insulin and to hold the insulin for blood sugars less than 120, which put Resident #12 at risk for hypoglycemia;<br>* Document the dosage, time, and administration of the pain medication Hydromorphone, which put Resident #14 at risk for increased pain and/or becoming over-medicated, which could have resulted in oversedation or respiratory compromise. Findings include:<br><br>1. Resident #12 was admitted to the facility on 7/8/14 with multiple diagnoses including Diabetes.<br><br>Resident #12's recapitulated Physician's Orders for 5/2015, and the MARs for 3/2015 and 4/2015, included the following insulin orders:<br>-Apidra Solostar prefilled pen 100unit/1ML insulin pen inject 18 units subcutaneously every morning with breakfast. Handwritten next to the typed order on the 3/2015 and 4/2015 MAR was "Hold if <120."<br>-Apidra Solostar prefilled pen 100unit/1ML insulin pen inject 16 units subcutaneously twice daily lunch/dinner.<br>-Apidra Solostar prefilled pen 100unit/1ML insulin pen inject prescribed number of units subcutaneously as directed per sliding scale: Check blood sugar (BS): if BS is 150-200 give 0 units, if BS is 201-250 give 2 units, if BS is 251-300 give 4 units, if BS is 301-350 give 6 units, if BS is 351-400 give 8 units, if BS is 400 or above call MD. | F 309 | changes were made to the medical records retroactively. As noted below, education was provided to staff for documentation going forward. The center has transitioned to licensed nurse electronic flow sheets with the ability for each nurse to self audit for completion between shifts. Shift report includes this self audit process and oversight by the clinical management team.<br><br>**Systemic Changes**<br>The SDC and/or DNS re-educated licensed nurses regarding complete and accurate documentation of the medical record, to include but not limited to, blood sugar monitoring, dialysis care, medication parameters for administration, bowel care, pain medication administration, and documentation of order clarification as needed. Additionally, education was provided to utilize the self audit process with the new electronic flow sheet and shift to shift report process. Clinical management is educated to review the timely/accurate documentation of electronic flow sheets.<br><br>**Monitor**<br>The DNS and/or designee will validate licensed nurse flow sheet completion daily in morning clinical review for 4 weeks, then twice weekly for 8 weeks. Starting July 9, 2015, 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 12 weeks, as it deems appropriate. | |

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|---|---|---|---|---|
| F 309 | Continued From page 14<br>- BG checks were scheduled for 7:00 AM, 12:00 PM, 5:00 PM, and 8:00 pm.<br><br>Note: All of the aforementioned Apidra orders originated on 11/17/14.<br><br>A faxed Physician Order, dated 2/27/15, documented "May hold Apidra if BG [blood glucose] < [less than] 120." The faxed order did not identify which dose of Apidra to hold, yet the physician's recapitulated physician's orders specified the hold order for the breakfast administration only.<br><br>The resident's 3/2015 Blood Glucose Monitoring Worksheet documented BG checks 4 times a day for 31 days. The BG checks documented between 6:00 AM and 7:05 AM were all below 120. However, Apidra 18 units was documented as administered on 3/2-4, 3/8-12, 3/16-18, 3/23-24, 3/26, and 3/29-31.<br><br>The 4/2015 Blood Glucose Monitoring Worksheet documented BG checks for 30 days. The BG checks documented between 6:00 AM and 7:00 AM were below 120 on 5 occasions. However, Apidra 18 units, was documented as administered on 4/1, 4/5-7, and 4/21.<br><br>The Apidra Insulin was administered 17 times in March and 5 times in April when the resident's BG was less than120.<br><br>On 6/4/15, the DNS stated Resident's #12's faxed order for Aprida needed clarification and insulin had been administered on days when the BG was less than 120. No new information was provided.<br><br>On 6/4/15, at 6:00 PM, the Administrator, DNS | F 309 | Date of Compliance<br>July 9, 2015 | |

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| F 309 | Continued From page 15<br>and the DDCO, were informed of the findings. There was no additional information provided by the facility.<br><br>2. Resident #7 was admitted to the facility 10/27/08 with multiple diagnoses including Paralysis Agitans (Parkinson disease).<br><br>Resident #7's most recent quarterly MDS assessment, dated 3/21/15, did not identify whether the resident was at risk for constipation, but documented the resident was not documented as being on a toileting program.<br><br>Resident #7's recapitulated Physician's Orders for 5/2015 and MARs for 3/2015 and 4/2015 documented:<br>-Milk of magnesia 400MG/5ML oral suspension, 30 ml by mouth as needed if no bowel movement for 2 days (DX: constipation).<br>-Bisac-evac [Dulcolax] 10mg suppository rectally at bedtime as needed if no bowel movement for 3 days (DX: constipation).<br>-Enema disposable 19g-7g/118 as directed rectally as needed if no bowel movement for 4 days (DX: constipation).<br>- Additionally, the resident had 4 other medications with constipation constipation as a potential side effect (Clozapine, Lexapro, Oxybutynin, and Clozaril).<br><br>Note: All of the aforementioned orders originated on 12/9/13<br><br>Resident #7's current Parkinson's Disease care plan interventions included:<br>- observe for, monitor, and document signs and symptoms of Parkinson's, including constipation. | F 309 | | |

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|---|---|---|---|
| | 135051 | A. BUILDING _____ B. WING _____ | 06/04/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 309 | Continued From page 16<br>Note: The resident's medical record did not include a direct care plan for constipation.<br><br>The resident ' s Flow Sheet Records documented the following:<br>- 3/2015: no bowel movement for 2 days from 3/3-3/4, 2 days from 3/6-3/7, 3 days from 3/12-3/14, for 3 days from 3/18 to 3/21, and 6 days from 3/23-3/28.<br>- 4/2015: no bowel movement for 8 days from 4/6-4/13, 3 days from 4/15-4/17, 4 days from 4/21-4/24, and 3 days from 4/28-4/30.<br><br>There was no documented evidence the resident received interventions as ordered for constipation in 3/2015 and 4/2015.<br><br>On 6/4/15 the DNS and the DDCO stated Resident's #7's bowel movements and interventions had not been documented.<br><br>On 6/4/15, at 6:00 PM, the Administrator, DNS and the DDCO, were informed of the findings. No additional information provided by the facility.<br><br>3. Resident #14 was admitted to the facility on 3/14/25 with multiple diagnoses including right total knee replacement and fibromyalgia. The resident was discharged home on 3/25/15.<br><br>The resident's Medication Administration record was incomplete, did not document a month, and was not signed by the physician. The dates for the 14th through 31st were handwritten in the boxes at the top of the page and documented the following:<br>- Hydromorphone 0.5 tab Q3 hours PRN<br>- Hydromorphone 1 tab Q3 hours PRN | F 309 | | |

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| F 309 | Continued From page 17<br>- Hydromorphone 2 tab Q3 hours PRN<br>- Hydromorphone 3 tab Q3 hours PRN - not to exceed 6 mg Q3 hours<br>These dosage were not documented in the physician's order, and there were a total of 19 initials under the dates for the 15th through the 19th. The documentation did not identify the times of day or night that the medication was given.<br><br>The Pharmacy Order Processing Report, dated 6/4/15, documented that on 3/14/15, 3 tabs of Hydromorphone 2MG were dispensed from the emergency kit for Resident #14. The aforementioned Hydromorphone orders did not have initials in the space provided for 3/14/15.<br><br>On 6/4/15 at 2:50 PM, the DNS stated the MAR was not dated and did not document times when Hydromorphone was given. The DNS stated she did not know if the resident received the Hydromorphone on the 3/14/15.<br><br>4. Resident #2 was readmitted to the facility on 7/5/13 with multiple diagnoses, including end stage renal disease (ESRD), chronic ischemic heart disease, diabetes mellitus (DM), atrial fibrillation (a-fib), and dementia.<br><br>The facility's policies and procedures for Residents Receiving Dialysis documented: "The center provides the necessary medical and nursing care and treatment to manage the resident's end-stage renal disease...Licensed nurses manage dialysis access site to maintain patency and adequate blood flow for dialysis. Plan of care include directives for managing the resident's needs end-stage renal disease." | F 309 | | |

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| | 135051 | A. BUILDING _____ B. WING _____ | 06/04/2015 |

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

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| F 309 | Continued From page 18<br><br>Resident #2's recapitulated May 2015 Physician's Orders documented:<br>Diabetes Mellitus:<br>5/30/13 - Blood glucose (BG) check before meals and at bedtime. Diagnosis: DM.<br>12/9/13 - Humalog 100 unit/1 ml unit-Give per sliding scale or per physicians order four times daily. Sliding Scale: 150-200=0 units; 201-250=1 unit; 251-300=2 units; 301-350=4 units; 351-400=6 units; >400=8 units and call MD.<br>7/31/14 - Lantus Solostar 100 unit/ml insulin pen-Inject 25 units subcutaneously at bedtime (HS). Hold if BG less than 120 for DM.<br>Atrial Fibrillation:<br>12/29/13 - Diltiazem 24 hr [hour] CD 120MG capsule 24 hour-Give 1 capsule by mouth every day for A-fib *Hold if Systolic blood pressure is less than 100 or heart rate is less than 60.<br>End Stage Renal Disease:<br>5/30/13 - Dialysis every Monday, Wednesday, and Friday.<br>12/22/14 - Renvela 800MG Tablet- Give 3 tablets by mouth three times daily with meals for ESRD.<br><br>The resident's current Care Plan documented:<br>*Focus- Diabetes Mellitus<br>Interventions- "Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness...Fasting Serum Blood Sugar as ordered by doctor..."<br>*Focus- Hemodialysis related to End Stage Renal Failure<br>Interventions- "Communicate with dialysis center regarding medications, diet, and lab results. Coordinate resident's care...Monitor access site upon return from dialysis for bleeding, redness, swelling, pain and non-functioning graft...Monitor shunt site by palpating for thrill and auscultating | F 309 | | |

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| F 309 | Continued From page 19<br>for bruit daily...Obtain vital signs and weight per protocol. Report significant changes in pulse, respirations and BP immediately..."<br><br>The resident's monthly Blood Glucose Monitoring Worksheets had boxes to document four daily BG assessments: AC-before each meal (Breakfast-AM, lunch-noon, and dinner-PM) and HS (at bedtime).<br>March 2015: The resident's BG was not checked on 3/22 for PM shift, 3/23 for HS shift, and 3/30/15 at HS.<br>April 2015: The resident's BG was not checked on 4/18/15 for PM shift.<br>May 2015: The resident's BG was not checked on 5/7 for PM shift, 5/26 for PM shift, and 5/30/15 for PM shift.<br><br>Resident #8's MAR documented:<br>Diabetes Mellitus:<br>Humalog 100 unit/1 ml unit-Give per sliding scale or per physicians order four times daily.<br>Lantus Solostar 100 unit/ml insulin pen-Inject 25 units subcutaneously at bedtime. Hold if BG less than 120 for DM.<br>*March 2015 MAR - 3/22, 3/23, and 3/30, the 10:00 PM spaces were blank for BG value, units of Humalog administered, site, and LN's initials. The Lantus 100 unit/ml-inject 25 units were documented as administered on 3/23 and 3/30, although the resident's BG was not documented and, therefore, it was unknown if the resident's blood glucose level was less than 120.<br>*April 2015 MAR - the 4/17 5:00 PM, and 4/18 12:00 PM and 5:00 PM spaces were blank for BG value, units of Humalog administered, site, and LN's initials.<br>*May 2015 MAR - 5/7, 5/26, and 5/30, the 5:00 PM spaces were blank for BG value, units of | F 309 | | |

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| | 135051 | A. BUILDING _____ B. WING _____ | 06/04/2015 |

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| F 309 | Continued From page 20<br>Humalog administered, site, and LN's initials.<br><br>A-fib:<br>Diltiazem 24 hr [hour] CD 120MG capsule 24 hour-Give 1 capsule by mouth every day for A-fib<br>**Hold if Systolic blood pressure (BP) is less than 100 or heart rate (HR) is less than 60.<br>*May 2015 MAR- 5/1-5/2, 5/7-5/8, 5/12, 5/14, and 5/16-5/31/15 spaces were blank for BP and/or HR results. The LNs' initials documented Dilitazem was administered daily throughout the month.<br>*June 2015 MAR- 6/1 and 6/2/15 spaces did not include an assessment of the resident's HR, however each space included the LNs' initials documenting Diltiazem had been administered.<br><br>ESRD:<br>Renvela 800MG Tablet- Give 3 tablets by mouth three times daily with meals for ESRD.<br>*April 2015 MAR - 4/25 for PM and 4/30/15 for Noon and PM spaces were blank for LN's initials, indicating the resident missed three doses of Renvela.<br>*May 2015 MAR- 5/23 for noon and PM, and 5/30/15 PM spaces were blank for LN's initials, indicating the resident missed three doses of Renvela.<br>5/30/13 - Dialysis every Monday, Wednesday, and Friday.<br><br>The resident's monthly Dialysis Log form provided areas for the LNs' documentation of the resident's vital signs and weight, completion of daily site care, observation of the atrial venous fistula site for bruit or thrill presence, observation of the access site for signs and symptoms (s/sx) of infection, and a post-dialysis session shunt site check every hour for 6 hours.<br>Resident #8's Dialysis Log documented the | F 309 | | |

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|---|---|---|---|
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| F 309 | Continued From page 21<br>following:<br>*March 2015:<br>Vital signs- Not completed on 3/11/15.<br>S/Sx of infection- Monitoring not completed on 3/1, 3/7, and 3/8/15.<br>Bruit or thrill present- Monitoring not completed on 3/1, 3/7, and 3/8/15.<br>Post-Dialysis Shunt Check every hour for 6 hours- Checks not completed on 3/2, 3/6, 3/9, 3/13, 3/16, 3/20, and 3/30/15.<br>*April 2015:<br>Vital signs- Monitoring not completed on 4/17, 4/24, 4/27 and 4/29.<br>S/Sx of infection- Monitoring not completed on 4/1, 4/7, and 4/8/15.<br>Bruit or thrill present- Monitoring not completed on 4/7 and 4/11/15.<br>Post-Dialysis Shunt Check every hour for 6 hours- Checks not completed on 4/3, 4/6, 4/10, 4/17, 4/24, 4/27, and 4/29/15.<br>*May 2015:<br>Vital signs- Monitoring not completed on 5/7, 5/13, 5/20, 5/22, 5/27, and 5/29/15.<br>S/Sx of infection- Monitoring not completed on 5/2, 5/9, 5/10, 5/20-5/23, and 5/27-5/30/15.<br>Bruit or thrill present- Monitoring not completed on 5/2, 5/9, 5/10, 5/20-5/23, and 5/27-5/30/15.<br>Post-Dialysis Shunt Check every hour for 6 hours- Checks not completed on 5/4, 5/6, 5/11, 5/18, 5/20, 5/25, 5/27, and 5/29/15.<br><br>On 6/4/15 at 8:50 AM, the DNS was interviewed with the DDCO present about Resident #2's diabetic care, ESRD and A-fib medication administrations, and dialysis care. The DNS acknowledged the resident's blood glucose monitoring had not been consistent, the resident missed some doses of his ESRD medication (Renvela), Diltiazem had been administered | F 309 | | |

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| F 309 | Continued From page 22<br>without monitoring BP and pulse daily as ordered, and staff were not monitoring the dialysis care consistently. The DDCO said the facility was in the process of converting to electronic MARs, which would rectify the numerous paper forms on which staff currently documented resident cares and monitoring.<br><br>On 6/4/15 at 5:55 PM, the Administrator, DDCO, and DNS were informed of the care issues. The facility did not provide any additional information to alleviate the concerns. | F 309 | | |
| F 312 SS=E | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, it was determined the facility failed to ensure showers and/or baths were consistently provided for 6 of 12 residents (#s 1, 2, 3, 7, 11 & 14) reviewed for ADL assistance. This deficient practice had the potential for more than minimal harm if residents experienced rashes, skin issues and/or unpleasant odors due to not being bathed regularly. Findings included:<br><br>1. Resident #2 was readmitted to the facility on 7/5/13 with multiple diagnoses including end stage renal disease, chronic ischemic heart disease, and dementia. | F 312 | This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation - Canyon West does not admit that the 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.<br><br>F312<br>**Resident Specific**<br>Resident #1, #2, #7 and #11 medical records were not adjusted as legally no retroactive changes can be made. Resident #3 and #14 are discharged from the center.<br><br>**Other Residents**<br>DNS review shows other resident records had similar deficient practices with incomplete documentation of shower/bathing. No changes were made to the medical records retroactively. As noted | |

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| F 312 | Continued From page 23<br><br>The resident's quarterly MDS assessment, dated 3/2/15, documented:<br>*BIMS of 14 - Intact cognition;<br>*Extensive assist of 1 staff for dressing, personal hygiene, and bathing; and,<br>*Frequently incontinent of bladder and occasionally incontinent of bowel.<br><br>The facility's Shower List documented the resident was to be showered on Mondays and Thursdays on the day shift. Also, any refusal was to be reported and a refusal form completed.<br><br>The facility's Flow Sheet Record documented the Nursing Order, "Shampoo, shower/bath 2 times a week. Fingernails and toenails cleaned and checked." The Flow Sheet Record had instructions, "Documentation of care given is completed by placing initials in the appropriate square."<br><br>The shower/bath Flow Sheet Record for Resident #2 documented:<br>*March 2015 - The resident did not bathe for seven days, from 3/8/15 until 3/15/15.<br>The resident did not bathe for 11 days, from 3/15/15 until 3/26/15. The resident refused a bath on 3/19/15, but was not given- or offered another bath/shower for 7 days.<br>* The resident did not bathe for 10 days, from 3/26/15 until 4/5/15.<br>*April 2015 - The resident did not bathe for eight days, from 4/5/15 until 4/13/15. The resident refused a bath on 4/9/15.<br>*May 2015 - The resident did not bathe for seven days, from 5/14/15 until 5/21/15.<br><br>On 6/2/15 at 9:15 AM, CNA #1 was interviewed | F 312 | below, education was provided to staff for documentation to include refusals and alternatives explored.<br><br>**Systemic Changes**<br>The SDC and/or DNS re-educated licensed nurses and Certified Nursing Assistants (CNAs) regarding completion of the bathing flow sheet, to include but not limited to, documentation of showers provided, those refused by the resident, those delayed when the resident is out of the center, and directives/alternatives provided with licensed nurse management.<br><br>**Monitor**<br>The DNS and/or designee will review bathing documentation daily on residents scheduled for a bath that day for 2 week, then will review 2 residents per week for 10 weeks. Starting July 9, 2015, documentation will take place on the PI Audit Tool. Any concerns will be addressed inmediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.<br><br>**Date of Compliance**<br>July 9, 2015 | |

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|---|---|---|---|
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| F 312 | Continued From page 24<br>about the residents' bathing schedules. The CNA said the floor CNAs are responsible for the baths now and it is very hard to "keep up." The CNA stated for "about 2 months now the shower aide has been gone and they do the best they can." The CNAs have a shower schedule assignment and the list was organized by resident and days of the week. If a resident refuses to bathe, the CNA said staff are to reapproach at a later time or another day, but this may not always occur.<br><br>2. Resident #11 was admitted to the facility on 3/3/15 with multiple diagnoses including congestive heart failure, Crohn's disease, and end stage coronary artery disease.<br><br>The resident's admission MDS assessment, dated 3/10/15, documented:<br>*BIMS of 6 - Severely impaired cognition;<br>*Extensive assist of 1 staff for dressing, personal hygiene, and bathing; and,<br>*Frequently incontinent of bladder and occasionally incontinent of bowel.<br><br>The facility's Shower List documented the resident was to be showered on Wednesdays and Saturdays on the evening shift. Also, any refusal was to be reported and a refusal form completed.<br><br>The facility's Flow Sheet Record documented the Nursing Order, "Shampoo, shower/bath 2 times a week. Fingernails and toenails cleaned and checked." The Flow Sheet Record had instructions, "Documentation of care given is completed by placing initials in the appropriate square."<br><br>The shower/bath Flow Sheet Record for Resident | F 312 | | |

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|---|---|---|---|
| | 135051 | A. BUILDING _____ B. WING _____ | 06/04/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 312 | Continued From page 25<br>#11 documented:<br>*March 2015 - The resident did not bathe for six days, from 3/3/15 until 3/9/15.<br>* The resident did not bathe for four days, from 3/13/15 until 3/17/15.<br>*April 2015 - The resident did not bathe for nine days, from 4/10/15 until 4/19/15.<br>* The resident did not bathe for eight days, from 4/20/15 until 4/28/15.<br>* May 2015 - The resident did not bathe for six days, from 4/30/15 until 5/6/15.<br>Note: There were no refusals documented on the shower/bath Flow Sheet Record nor the Nursing Progress Notes.<br><br>On 6/4/15 at 2:10 PM, the DNS, with the DDCO present, was interviewed regarding the inconsistent bathing of residents. The DNS said since the census had been down, the bathing responsibility of residents had been assumed by the CNAs. The DNS stated the showers missed were most likely thoses staff had failed to document as given or the resident refused and again staff failed to document.<br><br>On 6/4/15 at 5:55 PM, the Administrator, DDCO, and DNS were informed of the issue. The facility did not provide any additional information to alleviate the concern.<br><br>3. Resident #1 was admitted to the facility on 12/5/09 with multiple diagnoses including depression, dementia, anxiety and history of falls.<br><br>Resident #1's most recent quarterly MDS assessment, dated 4/3/15, coded 2 person physical assist for bathing, total dependence with | F 312 | | |

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|---|---|---|---|
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| KINDRED NURSING & REHABILITATION - CANYON WEST | 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605 |

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| F 312 | Continued From page 26<br>2-person physical assist for hygiene, and no refusals.<br><br>The Shower List, dated 5/19/15, documented Resident #1 was to have showers on Mondays and Thursdays, and any refusal was to be reported to the nurse and a refusal form filled out.<br><br>The Flow Sheet documented, "Shampoo, shower/bath 2 times a week..."<br>- 12/2014: No bath/shower from 12/5-12/10 (6 days), 12/16-12/21 (6 days), and from 12/26-12/31 (6 days).<br>- 2/2015: No bath/shower from 2/3-2/8 (6 days) and from 2/20-2/25 (6 days).<br>- 3/2015-4/2015: No bath/shower from 3/31/15-4/5/15 (6 days), and from 4/24-4/29 (6 days).<br><br>On 6/4/15 at 11:40 AM, the DNS was informed of the findings for Resident #1. No additional information was provided.<br><br>4. Resident #7 was admitted to the facility on 10/27/08 with multiple diagnoses including Paralysis Agitans (Parkinson disease), and dementia.<br><br>The resident's most recent quarterly MDS assessment, dated 3/21/15, coded one person physical assist for bathing and personal hygiene and no refusals.<br><br>The Shower List, dated 5/19/15, documented Resident #7 was to have showers on Wednesdays and Saturdays and any refusal was to be reported to the nurse and a refusal form was to be filled out. | F 312 | | |

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| | 135051 | A. BUILDING _____ B. WING _____ | 06/04/2015 |

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|---|---|
| KINDRED NURSING & REHABILITATION - CANYON WEST | 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605 |

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|---|---|---|---|---|
| F 312 | Continued From page 27<br>The Flow Sheet documented, "Shampoo, shower/bath 2 times a week..."<br>- 3/2015: No bath/shower for 3 days on 3 occasions, from 3/1-3/3, 3/8-3/10, 3/15-3/17, and 3/22-3/24.<br>- 4/2015: No bath/shower from 4/5-4/8 (4 days) and from 4/26-4/30 (5 days)<br><br>On 6/4/15 at 11:40 AM, the DNS was informed of the findings for Resident #7. No additional information was provided.<br><br>5. There were similar findings for Residents #3 and #14, in regards to consistent baths and/or showers. The facility's documentation on the shower/bath Flow Sheet Record reflected both residents had missed baths/showers and no refusal form completed.<br><br>On 6/4/15 at 5:55 PM, the Administrator, DDCO, and DNS were informed of the bath/shower concerns. The facility did not provide any additional information to alleviate the issue. | F 312 | | |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>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. | 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. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 135061 | A. BUILDING _____ B. WING _____ | 06/04/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| KINDRED NURSING & REHABILITATION - CANYON WEST | 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 |
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| F 315 | Continued From page 28<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interview, it was determined the facility failed to ensure residents with urinary catheters received necessary care and services for prevention of complications related to catheters. This was true for 1 of 4 residents (#3) reviewed for urinary catheter care. This deficient practice created the potentional for harm when Resident #3 developed a urinary tract infection (UTI) with the potential for serious complications due to inadequate care with his suprapubic catheter. Findings included:<br><br>Resident #3 was readmitted to the facility on 3/9/15 with multiple diagnoses including chronic kidney disease, dementia, hypertrophic prostate with ureter obstruction, recurrent UTIs with hospitalization for sepsis, and a suprapubic catheter.<br><br>The 3/16/15 admission MDS assessment documented:<br>*BIMS of 11 - Cognition moderately impaired;<br>*Total support with 2 staff assist for transfers;<br>*Extensive assist of 1 staff for dressing, toilet use, and personal hygiene; and,<br>*Indwelling catheter.<br><br>The resident's June 2015 recapitulation Physician's Orders and 6/1/15 Physician Order documented:<br>4/27/15: "Suprapubic catheter 16FR [French] 30CC [cubic centimeters] balloon change every month on the 27th day of the month and as needed."<br>6/1/15: "Ceftriaxone 1 gm [gram] IM [intramuscular] daily for 5 days."<br>6/1/15: "Please change catheter once Antibiotics | F 315 | F315<br>**Resident Specific**<br>Resident #3 has been discharged from the center.<br><br>**Other Residents**<br>Clinical Management team completed rounds and observed residents with catheters to have the drainage bag positioned lower than the bladder with appropriate tubing positioning. No adjustments were indicated.<br><br>**Systemic Changes**<br>SDC and/or DNS have re-educated the licensed nurse staff and CNA staff regarding care of indwelling catheters, to include but not limited to, position of the drainage bag and tubing. Licensed nurses will validate catheter placement during medication administration rounds. Clinical management team will validate catheter placement during clinical rounds.<br><br>**Monitor**<br>The DNS and/or designee will make clinical rounds daily on two residents for 2 weeks to include observation of catheter drainage bags and tubing positioned to prevent potential backflow. Two residents will be reviewed weekly for an additional 10 weeks. Starting July 9, 2015 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 12 weeks, as it deems appropriate. | |

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| F 315 | Continued From page 29<br>started."<br><br>Resident #3's Care Plan for an indwelling suprapubic catheter, dated 1/14/15, documented:<br>* "Cath [catheter] care BID [twice a day], report anomalies to MD as needed."<br>* "Change catheter every 4 weeks."<br>* "Position catheter bag and tubing below the level of the bladder..."<br>* "Check tubing for kinks each shift."<br>* "Monitor and document intake and output as per facility policy."<br>* "Monitor/record/report to MD for s/sx [signs/symptoms] UTI..."<br><br>The resident's MAR/TAR record documented:<br>*The resident's catheter was changed on 5/5/15 and 5/15/15 due to occlusion. The catheter was changed again on 5/29/15. The TAR documentated the catheter was changed on 6/2/15 after the antibiotics were started.<br>*The resident's Ceftriaxone injections were administered on 6/1/15 through 6/5/15 as ordered.<br><br>On 6/1/15 at 9:30 AM, during the initial tour of the facility, the resident was observed while seated in his geri chair, which was reclined to 30 degrees. Resident #3's catheter tubing was placed to his left side on the seat of his chair. The tubing was observed to be at the same height as or above the resident's bladder. The catheter tubing had yellow urine the full length of the tube to the catheter bag and up as far as could be seen without disrupting the resident's clothing to identify the insertion site.<br><br>On 6/2/15 at 9:20 AM and 6/3/15 at 9:40 AM, the resident was observed lying on his back in his | F 315 | Date of Compliance<br>July 9, 2015 | |

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| F 315 | Continued From page 30<br>bed with his head elevated to 30 degrees and his feet elevated to 25 degrees. The resident's buttocks was at the bend in the bed. His foley bag was in a privacy bag hung on the left side and underneath the bed frame. The catheter tubing was visible coming over the top of his thigh and a pillow which had been laid alongside the resident's left side. There was yellow urine in the tubing from the outer edge of the pillow back towards the resident.<br><br>On 6/3/15 at 9:45 AM, LN #3 was interviewed about the positioning of Resident #3's catheter tubing. The LN stated, "That's not correct. It should be laying down off the pillow so there's no backflow." The LN removed the pillow by the resident's left side, placed the catheter tubing alongside the resident's leg and over the edge of the bed, and ensured the catheter tubing was below the resident's bladder and draining with no resistance.<br><br>On 6/4/15 at 5:55 PM, the Administrator, DDCO, and DNS were informed of the concerns. The facility did not provide any additional information to alleviate the issue. | F 315 | | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>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. | 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. | |

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| F 323 | Continued From page 31<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of incident reports and staff interviews, it was determined the facility failed to ensure adequate supervision was provided to prevent falls. This was true for 1 of 14 (#12) sampled residents. Resident # 12 was at risk for harm if a fall resulted in a fracture or head injury and hospitalization or surgical intervention was required. Findings include:<br><br>Resident # 12 was admitted to the facility on 7/8/14 with multiple diagnoses including Alzheimer's disease, dementia, muscle weakness, peripheral neuropathy, and generalized pain.<br><br>The two most recent quarterly MDS assessments, dated10/15/14 and 2/26/15, coded the resident was severely to moderately cognitively impaired, had disorganized thinking, and required extensive to total assist from 1-2 people for bed mobility, transfers, walking, dressing, toileting, personal hygiene, and bathing.<br><br>The current Care Plan (CP) documented the resident had impaired cognitive function related to dementia and depression, ADL deficiencies related to limited range of motion, activity intolerance and poor coordination, bladder incontinence related to Alzheimer's and was at high risk for falls related to confusion, gait/balance problems and history of falls. Interventions included:<br>- Room close to nurse ' s station for increased traffic (11/28/14)<br>- Required 1 staff for toilet use and was not to be left unattended when in the bathroom (11/28/14)<br>- Required 2 person staff assistance for transfers | F 323 | **F323**<br>**Resident Specific**<br>Resident #12's care plan was reviewed and updated by the ID team to include increased supervision as indicated.<br><br>**Other Residents**<br>Clinical Management team reviewed residents with falls for adequate supervision to prevent falls. Care plans were updated as indicated<br><br>**Systemic Changes**<br>SDC and/or DNS re-educated nursing staff regarding adequate supervision to prevent falls to include but not limited to,<br>▪ More detail that includes identification of root cause and specifically how the plan implemented provides additional supervision.<br>▪ Care plan intervention changes that address root cause. Do not re-state items already in place that are effective in the plan.<br>Prevention of falls is reviewed through shift-to-shift report, daily clinical management meeting, event investigation, and clinical rounds.<br><br>**Monitor**<br>The DNS and/or designee will review each fall with the ID team for thorough investigation and identification of root cause. The plan will be validated as addressing the root cause to include but not limited to increased supervision. Each resident with a fall will be reviewed for 4 weeks, than one resident with a fall will be reviewed weekly for 8 weeks. Starting July 9, 2015 documentation will take place on | |

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| F 323 | Continued From page 32<br>(11/28/14)<br>- Prompted voiding and staff were to ask the resident to use the toilet before the next scheduled time for toileting (11/28/14)<br>- Routine toileting with AM and PM cares and as needed (11/28/14)<br>- Supervision and assistance for all decision making (11/29/14)<br>- Favorite past time was reading (11/29/14)<br>- Assist to room after meals and with toileting (3/23/15)<br>- Alarm placed on bathroom door (4/17/15)<br>- Toilet resident before assisting to bed (5/26/15)<br><br>The Incident Reports (IR) on 12/26/14, 2/28/15, 3/8/15, 3/22/15, 4/17/15, 5/15/15, and 5/23/15, documented the resident had a total of 7 falls in 6 months and documented the following:<br><br>The 12/26/14, IR documented:<br>- The resident did not call for assistance, self-transferred to the bathroom, lost her balance, and fell to the floor.<br>- Recommendations were to monitor for injuries, assist the resident to and from meals, assist with toileting after meals and offer toileting every 2 hours.<br><br>The 2/28/15, IR documented:<br>- The resident did not call for assistance, self-transferred, was confused to time and situation related to dementia, and was found on the floor at the foot of the bed at approximately midnight.<br>- Recommendations were to monitor for injuries, keep the bed in low position, keep the bathroom light on at night, and toilet the resident in the pm/noc (night) shifts. | F 323 | 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 12 weeks, as it deems appropriate.<br><br>**Date of Compliance**<br>July 9, 2015 | |

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| F 323 | Continued From page 33<br>The 3/8/15, IR documented:<br>- The resident did not call for assistance, attempted to stand at the medication cart, lost her balance, and was assisted to the floor by a CNA.<br>- Recommendations were to monitor for injuries, and offer the resident a book or magazine to read when the resident was not in sight or engaged with another resident.<br><br>The 3/22/15, IR documented:<br>- The resident did not call for assistance, self transferred, was found sitting on the bathroom floor, and reported hitting her cheek when falling.<br>- Recommendations were to monitor for injuries, assist back to room after meals, assist with toileting and "CNA education related to kardex and reviewing more frequently."<br><br>The 4/17/15, IR documented:<br>- The resident did not call for assistance, self transferred to the bathroom and fell to her buttocks.<br>- Recommendations were to monitor for injuries, bathroom door alarm placed, and offer toileting before and after meals.<br><br>The 5/15/15, IR documented:<br>- The resident had 2 seizures the day before, had been more confused and lethargic, did not call for assistance, self-transfered out of bed and was found sitting on the floor next to the bed.<br>- Recommendations were to monitor for injuries, "provide cares and assist up to wheelchair half way between lunch and breakfast," and "encourage to stay up after breakfast."<br><br>The 5/23/15 IR, documented:<br>- The resident attempted to reach for something, slid out of bed, and was found on the floor after | F 323 | | |

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| F 323 | Continued From page 34<br>the resident ' s roommate put the call light on.<br>- Recommendations were to monitor for injuries, larger bed with bolsters for positioning and continue to toilet the resident before assisting to bed.<br><br>Note: The incident reports did not identify increased supervision at any time.<br><br>On 6/4/15 the following observations were made: At 8:30 AM, Resident #12 was observed sitting in her wheelchair in the medical record room. Resident #4 was sitting next to her. Both residents were in front of a table that was not within arms' reach and were positioned to face the same back wall. Neither resident was engaged in conversation with each other or with staff. Neither resident had a magazine, book or activity. RN #2 was walking around the medical chart room working and looking at the computer and intermittently looking at the residents.<br><br>At 8:45 AM, on 3 occasions, Resident #12 attempted to stand from her wheelchair. RN #2 first observed the resident on the third attempt and unsuccessfully attempted 4 times to redirect the resident before the resident was taken from the room by RN #2 at 8:50 AM.<br><br>At 8:55 AM, the Activities Director stated the resident enjoyed looking at magazines, which kept her occupied.<br><br>At 9:00 AM, RN #2 stated Resident #12 was in the medical chart room for increased supervision secondary to increased agitation and confusion.<br><br>At 4:00 PM, the DNS stated a door chime, locating the resident's room across the hall from | F 323 | | |

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| F 323 | Continued From page 35<br>the DNS office (care planned on 11/28/14), and placing the resident with an alert and oriented roommate was considered extra supervision and preventative measures. The DNS stated there was not a care plan for ensuring the bathroom door was closed in order for the chime to work as planned.<br><br>On 6/4/15 at 5:55 PM, the Administrator, DDCO, and DNS were informed of the findings. The facility did not provide any additional information to alleviate the findings. | F 323 | | |
| F 431 SS=E | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, | F 431 | 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.<br><br>F431<br>**Resident Specific**<br>The outdate medications and insulin pens for discharged residents #14 through #21 were destroyed during the survey.<br><br>**Other Residents**<br>The clinical management team completed medication room/refrigerator and medication cart audits to validate no additional expired items were available for use. No additional items were identified. | |

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| F 431 | Continued From page 36<br>permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, it was determined the facility failed to ensure an expired bottle of Calcitonin Salmon nasal solution, an expired bottle of Metamucil MultiHealth Fiber, and an expired insulin pen were removed from the medication supply refrigerator. Additionall, the facility failed to ensure 23 insulin pens for a number of discharged residents had been disposed of properly. This deficient practice created the potential for decreased efficacy for any resident who could have received the Metamucil, Calcitonin Salmon nasal solution, and/or the insulin, and the facility had not maintained safe handling for the disposition of 23 insulin pens. Findings included:<br><br>On 6/23/15 at 2:10 PM, during inspection of the Medication Room and Medication Refrigerator with the Staff Development Coordinator (SDC) present, the following medications were found:<br>*1 15 ounce bottle of Metamucil MultiHealth Fiber with 72 doses, which expired 5/2015;<br>*1 bottle Calcitonin Salmon Nasal Solution, which expired 3/2015, for Resident #21who had discharged from the facility on 4/10/14;<br>*1 opened Lantus Solostar Pen for Resident #15 | F 431 | **Systemic Changes**<br>The SDC and/or DNS has re-educated licensed nurse staff to the drug and biological expiration dates to include but not limited to, management of discharged resident medication.<br><br>**Monitor**<br>The night nurse will complete review for expired and/or discharged resident medications and solutions one time a week for two months, then every two weeks for two months. Starting July 9, 2015, documentation will take place on the PI Audit Tool.<br><br>In addition, the center Omnicare Consulting Pharmacist and Omnicare Nursing Consultant will perform spot checks of the medication room and medication carts for any expired and/or discharged resident medications/solutions during their respective monthly and quarterly visits.<br><br>The DNS is assigned oversight for sustained compliance. 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 12 weeks, as it deems appropriate.<br><br>**Date of Compliance**<br>July 9, 2015 | |

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|---|---|---|---|---|
| F 431 | Continued From page 37<br>who discharged from the facility on 1/15/15. The pen was opened 12/15/14 and should have been discarded within 28 days;<br>*1 unopened Lantus Insulin Solostar Pen for Resident #16, who discharged from the facility on 12/13/14;<br>*9 unopened Humalog Insulin Kwik Pens for Resident #17, who discharged from the facility on 4/14/14;<br>*3 unopened Novolog Insulin Flex Pens for Resident #18, who discharged from the facility on a date not provided by the facility;<br>*5 unopened Novolog Insulin Flex Pens for Resident #19, who discharged from the facility on 4/2/14; and,<br>*5 unopened Lantus Insulin Solostar Pens for Resident #20, who discharged from the facility on 2/4/14.<br><br>During the inspection on 6/3/15 at 2:10 PM, the SDC was interviewed regarding the expired medications and the disposition of the 23 insulin pens for residents, who had discharged 5 months to more than a year prior from the facility. The SDC stated, "These pens shouldn't be here, they should be in the pharmacy bins to return. It isn't our process. These pens should be in the med fridge in the charting room. I'm embarrassed they are there."<br><br>On 6/4/15 at 5:55 PM, the Administrator, DDCO, and DNS were informed of the medication concerns. The facility did not provide any additional information to alleviate the issue. | F 431 | | |

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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September 22, 2015

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

Provider #: 135051

Dear Mr. Schulkins:

On **June 4, 2015**, an unannounced on-site complaint survey was conducted at Kindred Nursing & Rehabilitation - Canyon West.

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from June 1 to June 4, 2015.

The following observations were completed:

Call lights were observed throughout the survey, and
Medication pass was observed.

The following documents were reviewed:

- The entire medical record of the identified resident;
- 12 other residents' records were reviewed for Quality of Care concerns;
- The facility's Grievance file;
- Resident Council minutes;
- The facility's Incident and Accident reports; and,
- The facility's Allegation of Abuse reports.

The following interviews were completed:

- Several residents were interviewed regarding Quality of Care and Quality of Life concerns;
- 13 residents were interviewed during the Resident Group Interview regarding Quality of Care and Quality of Life concerns;
- Several residents family members were interviewed regarding Quality of Care and Quality of Life concerns;
- Several staff members were interviewed regarding call light response times;
- The Director of Nursing and the Administrator were interviewed regarding various Quality of Care concerns;
- The Director of Rehabilitation was interviewed regarding therapy concerns;
- Several staff members were interviewed regarding call lights and Quality of Care concerns; and,
- A Social Worker was interviewed regarding the procedure for resident discharges.

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

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006952**

ALLEGATION #1:

The complainant stated an identified resident did not receive pain medications in a timely manner.

FINDINGS #1:

Based on record review and staff interview, it was determined the allegation was substantiated and cited at F309.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated an identified resident did not receive an adequate amount of baths.

FINDINGS #2:

Based on record review and staff interview, it was determined the allegation was substantiated and cited at F312.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

The complainant stated there was a delay in treatment when a continuous passive motion (CPM) machine was not provided for an identified resident and then was not used by staff as ordered by the physician.

FINDINGS #3:

The entire record of the identified resident was reviewed, and
Several resident's records who had therapy were reviewed.

13 residents were interviewed during the Resident Group Interview regarding Quality of Care concerns;
Several residents and family members were interviewed; and, the Director of Rehabilitation was interviewed.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated call lights took too long to be answered by facility staff.

FINDINGS #4:

Call lights were observed throughout the survey.

The entire record of the identified resident was reviewed;
The facility's Grievance file was reviewed; and, Resident Council minutes were reviewed.

Several residents were interviewed regarding Quality of Care and Quality of Life concerns;
13 residents were interviewed during the Resident Group Interview regarding Quality of Care and Quality of Life concerns;
Several resident's family members were interviewed regarding Quality of Care and Quality of Life concerns;
Several staff members were interviewed regarding call light response times; and,
The Director of Nursing was interviewed regarding call light response times

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated there was conflicting information from facility staff regarding an identified resident's discharge planning.

FINDINGS #5:

The entire medical record of the identified resident was reviewed;
One other resident's records were reviewed for discharge planning; and, the facility's Grievance file was reviewed.

The Director of Rehabilitation was interviewed regarding therapy concerns and discharge planning, and a Social Worker was interviewed regarding the procedure for resident discharges.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant said the food was cold, mushy and lacked flavor.

FINDINGS #6:

The facility's Grievance file was reviewed, and Resident Council minutes were reviewed.

Several residents were interviewed regarding food concerns;
13 residents were interviewed during the Resident Group Interview regarding food concerns; and, several resident's family members were interviewed regarding food concerns.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,

Nina Sanderson, LSW, Supervisor
Long Term Care

NS/sr